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Theoretical and Clinical Investigation into the Concept of Mental Contamination in Relation to OCD and its Relationship with Mental Health Difficulties.

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Theoretical and Clinical Investigation into the Concept of Mental Contamination in Relation to OCD and its Relationship with Mental Health Difficulties.

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Abstract

Cognitive theories of Obsessive-compulsive disorder (OCD) emphasise mis-appraisal of intrusive cognitions in terms of responsibility for harm which motivates neutralising behaviour. Sufferers experience intense fear, distress and problematic behaviours as vicious circles which maintain the problem. CBT focusses on these maintenance factors to the extent that these are identifiable. In some instances, these factors may be closely linked to historical and developmental issues.

Contamination is a common subtype of OCD, and recent work has suggested the importance of Mental Contamination (MC) as an internal form not requiring physical contact to be triggered; it may be linked to memories of past associations with the triggering stimuli. Morality seems to be important and MC has been associated with betrayal, degradation, humiliation and attacks on self-perception; this can all be experienced when bullied.

The programme of research described here focusses on bullying as a traumatic life event. which can result in the development of problematic associations with "obsessional" stimuli and motivate compulsive behaviour. Bullying is known to be a potent life event linked to a range of mental health problems (MHP) and related difficulties. The first study was conducted on a general population sample, divided by bullying experiences (yes n=39, no n=54). Participants who reported bullying scored significantly higher on measures of OCD, MC, anxiety and depression. Study 2 focussed on therapists' attitudes towards bullying (n=*62*); all believing bullying affects MHP including OCD. Study 3 was based on an OCD sample (bullied n=16, not n=4) and a control group (bullied n=11, not n=32); 80% of clinical participants reported experiencing bullying.

Results suggest a relationship between bullying, OCD, and MC. This relationship is more complex than just the anxiety component. When depression and anxiety were controlled for, there was still an association. If confirmed, this relationship has implications for treating and preventing MC.

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Chapter 1 - Mental contamination

Introduction

Can dirty deeds make you feel dirty? Although Mental Contamination (MC) is a relatively new concept within clinical psychology, originally introduced in 1994 by Rachman (Rachman 1994, Garnett, Masyn et al. 2014), the phenomenon has been historically alluded to. MC can be clearly identified in Shakespeare's Macbeth written in 1606. Lady Macbeth is seen to wash her hands of the guilt after realising the murder committed by Macbeth, *"My hands are as red as yours…a little water will wash away the evidence of our guilt"* (Shakespeare 2005). Lady Macbeth did not physically commit the murder, yet feels compelled to cleanse herself. So why does Lady Macbeth feel the urge to physically wash?

The Bible also seems to document an occurrence of MC in relation to the guilt felt by Pontius Pilate as he sought to evade responsibility for his actions. According to the Bible, he agreed to the death of Jesus but felt that he had to wash his hands consequently, *"he took water and washed his hands in front of the crowd. "I am innocent of this man" he said. "it is your responsibility""* (Biblica 2011). As with Lady Macbeth, he had no physical involvement in the death, and yet had the urge to physically wash his hands; but why the need for physical cleansing? This is one of several questions the author will seek to illuminate in this thesis.

According to Rachman (Rachman 1994, Rachman 2004, Rachman 2006), MC is a fear of contamination that is purely cognitive in nature. It is defined as a feeling of internal dirtiness, often with moral foundations, linked to "Pollution of the mind" (Rachman 1994). He suggests that it can be provoked by intrusive thoughts, memories, impulses, or by the accusations or violations of other human beings. MC is associated with specific negative emotions including guilt, shame, fear, disgust and anger, amongst others (Rachman 2004, Rachman 2006, Coughtrey, Shafran et al. 2014, Coughtrey, Shafran et al. 2014). MC can explain why both Lady Macbeth and Pontius Pilate felt compelled to physically wash; to wash away the associations of guilt and shame that were experienced as a result of their memories of an awful incident that both characters found themselves involved in.

In this chapter, MC will be described in terms of its theoretical understanding, phenomenology, compulsive behaviours associated with the contact as well as treatment strategies. The author will also discuss diagnostic issues, how MC is associated with both Obsessive-Compulsive Disorder (OCD) & post-traumatic stress disorder (PTSD), and other psychological problems.

Phenomenology of MC

MC appears to be most strongly associated with memories of traumatic, unpleasant events. The key difference between typical fears of contamination and MC, the latter is a feeling of internal dirtiness that can be triggered without the contaminant (the person who causes the feeling of dirtiness) being present or physically touched (Rachman 2004, Rachman 2006). Reminders of the person or experience

such as memories, intrusive thoughts, or even particular smells can result in an individual feeling dirty and indulging in neutralising behaviours. It is important to note here that, even though compulsive washing is one of many neutralising behaviours (discussed later in this chapter), it is almost always ineffective because the contaminated area is inaccessible; it simply can't be washed away. This causes many patients to report the experience as being a matter of 'looking clean, but feeling dirty' (Rachman, 2004, 2006). This is because the patient appears clean externally due to the washing, but still feels internally dirty. Before returning to a detailed examination of the correlates of MC, we will now consider the diagnostic and phenomenological context.

Diagnostic dilemmas

The concept of MC becomes quite confusing when diagnostic criteria are considered. Currently, MC is acknowledged as a subtype of obsessive-compulsive disorder (OCD) according to the literature (Rachman 2004, Rachman 2006, Coughtrey, Shafran et al. 2011, Coughtrey, Shafran et al. 2012).

Theories of OCD have rapidly evolved, moving away from the psychodynamic view revolving around the idea of weak ego boundaries, to our modern-day cognitive approach (Salkovskis 1999). Rachman has been instrumental in the development of such a theory, arguing in as early as 1971 that obsessive problems are far too complex to be analysed with simple psychodynamic or behaviourist approaches (Rachman 1971, Rachman, Hodgson et al. 1971, Rachman 1976). Although the theory is largely based on Beck's cognitive model (Beck and Clark 1997), the likes of Rachman and Salkovskis amongst others, have continued to develop our knowledge of the disorder through empirical investigations (Rachman 1976, Salkovskis 1985, Rachman 1994, Rachman, Thordarson et al. 1995, Salkovskis 1999, Salkovskis, Shafran et al. 1999, Rachman 2004, Rachman 2006).

In general, OCD has a lifetime prevalence rate of roughly 1% (American Psychiatry Association 2000, Torres, Prince et al. 2006). The disorder revolves around distortions or inaccurate appraisals in relation to risk and/or the responsibility of causing harm to oneself or others. Individuals diagnosed with OCD will experience obsessional problems, which can be persistent images, memories, intrusive thoughts, impulses that cause the person to experience anxiety. As a result, the individual will indulge in compulsions, which are neutralising behaviours or mental ruminations that are performed to try and alleviate their distress.

Salkovskis introduced the idea of an inflated sense of responsibility (Salkovskis 1985, Salkovskis, Shafran et al. 1999). The idea is that a person mis-appraises their intrusive thoughts in terms of threat and responsibility, and has to engage in ritualistic behaviours as a result. (Salkovskis 1985, Salkovskis, Shafran et al. 1999). Compulsions are therefore the individuals attempt to avoid or prevent the negative incident occurring, and reduce the sense of responsibility. Obsessions can appear to be quite illogical and the sufferer is usually aware of this, but the thoughts cause the individual to feel responsible to such an extent that it provokes

both feelings of anxiety and distress and results in obsessive and compulsive behaviour. This then sets in motion a vicious cycle as the neutralising behaviour did seem to prevent the negative event, so the behaviour must be repeated to ensure the incident does not occur in the future. For example, a person who may experience or hear about a house fire due to an oven being left on may worry and begin to obsess that a fire may start in their house. The individual could begin checking appliances are switched off repeatedly, throughout the day. The person may then attribute the prevention of a fire to the checking behaviour and feel compelled to repeat the behaviour, more and more rigorously in some cases.

It is these neutralising behaviours that has partly led to the development of a relatively affective form of treatment. As with the disorder itself, the treatment of OCD has evolved significantly from psychodynamic interventions. Unsurprisingly, a behaviourist approach to treating obsessional problems was accepted for a few years. The approach focussed on the patient maintaining low levels of anxiety whilst being slowly and systematically desensitised to the anxiety-provoking stimuli. It took Rachman's intervention again to apply more complex aspects to the therapy setting and develop cognitive-behavioural therapy (CBT), which is so affective today (Rachman, Hodgson et al. 1971, Rachman 1976, Salkovskis 1985, Salkovskis 1999).

CBT continues to develop as a treatment strategy as our knowledge of psychological problems improves, and can be tailored to treat a variety of different conditions, from anxiety disorders to psychosis; it can also be adjusted to suit different patients with very specific symptoms. The approach does not set out to 'prove' the patient's obsessions are incorrect, as this may actually exacerbate the obsessional problems. Instead, the service user is guided to consider their problems from a different perspective, that of worry about harm rather than harm itself. With a positive, trusting relationship between patient and therapist, CBT is employed using various strategies such as creating goals, psychoeducation, reappraisals, challenging ideas of responsibility, encouraging service user engagement in treatment activities, and exposure and response prevention (Salkovskis 1999).

The exposure and response prevention (ERP) technique can be extremely effective in individuals diagnosed with OCD. Patients are exposed to their obsessional problem, be it dirt, a situation, or an idea, and are prevented from performing their neutralising behaviour. This is how Rachman developed his idea of MC; individuals with fears of contamination responded extremely positively to the treatment technique, but a minority of service users failed to improve. Rachman realised that their fears differed slightly and published his original theory of 'pollution of the mind' in 1994 (Rachman 1994). Although we now use the term "Mental Contamination', I still feel the word 'pollution' is relevant, but this will be discussed later in the thesis.

Rachman considered MC a subtype of OCD (Rachman 1994, Fairbrother and Rachman 2004, Fairbrother, Newth et al. 2005, Rachman 2006), but how strong is the evidence that this is actually the case? A large amount of research into MC focussed on sexual assault, leading to researchers reporting that individuals diagnosed with post-traumatic stress disorder (PTSD) can develop MC (Ehlers, Clark et al. 1998, Dunmore, Clark et al. 1999, Steil, Jung et al. 2011, Badour, Feldner et al. 2013, Elliott and Radomsky 2013). Some victims of sexual assault report feelings of contamination months after the attack (Fairbrother and Rachman 2004, Badour, Feldner et al. 2013, Ishikawa, Kobori et al. 2013).

So, research suggests that fears on contamination can be experienced by both individuals suffering with OCD and PTSD. Furthermore, recent research has begun to explore the idea that possibly MC is not just symptoms shared by victims of immoral acts. It is plausible to suggest that the perpetrators also develop MC (discussed later in this chapter).

Interestingly, in relation to PTSD, MC has only been explored in patients who have experienced sexual assault rather than other traumatic incidents such as war (Dunmore, Clark et al. 1999, Badour, Feldner et al. 2013, Adams Jr, Badour et al. 2014). As MC in OCD revolves around immoral behaviour in the sense of being mistreated, as well as behaving in ways that are inconsistent with the person's morals and values, it is plausible to suggest that MC could potentially be triggered by other traumatic incidents without the occurrence of PTSD. For example, in a war environment, if a fellow soldier is injured or killed, and an individual feels guilty because they could have done more to prevent the incident (taking responsibility), feelings of internal dirtiness may begin.

There do seem to be cases where the individual reports feelings of MC which fit better within a diagnosis of either OCD or PTSD. There may be cases where the service users should be diagnosed with mental contamination as a disorder with obsessional problems (Warnock-Parkes, Salkovskis et al. 2012, Elliott and Radomsky 2013).

Theoretical understanding

Although initially introduced by Rachman in 1994 (Rachman 1994), empirical research into MC began in 2004 (Fairbrother and Rachman 2004). MC is regarded as similar to Contact Contamination (CC), a frequent symptom of OCD (Rachman 2004, Rachman 2006), but has considerable differences which will be discussed throughout this chapter.

As with OCD in general, there is evidence that fears of contact contamination can decay with the passage of time, causing a reduction in symptoms and distress (Rachman 2006, Coughtrey, Shafran et al. 2014, Coughtrey, Shafran et al. 2014). There is also evidence that neutralising behaviours such as compulsive washing can impede the decay process, and may therefore maintain the problem (Rachman 2004, Rachman 2006, Coughtrey, Shafran et al. 2014, Coughtrey, Shafran et al. 2014). So, every time an individual with contamination-related OCD performs

their washing rituals they are inhibiting the decay process and prolonging their distress.

The same process may also occur with MC (Coughtrey, Shafran et al. 2014, Coughtrey, Shafran et al. 2014). Research suggests that feelings of internal dirtiness do decay in time if neutralising behaviours are prevented in non-clinical participants. This seems to contrast with Rachman's theory of MC in the context of clinical OCD; he argues that this form of contamination is much more resistant to extinction than typical CC (Rachman 1994, Rachman 2004, Rachman 2006). This may be related to the way in which MC is triggered, as well as the neutralising behaviours associated with this form of contamination. With CC, a patient requires another physical interaction with the contaminant object to trigger contamination fears. As mentioned above, MC can be provoked by even a fleeting memory of a situation that included a violation or immoral behaviour to some degree. The triggers for MC are much more accessible than that of CC; MC can be provoked by one's own cognitions particularly by association with memories of key events. As a result, the decay process is inhibited (Rachman 2004, Rachman 2006, Coughtrey, Shafran et al. 2014, Coughtrey, Shafran et al. 2014).

In terms of neutralising behaviour, they may also add to the perception of MC being a more robust form of contamination. Although individuals do report washing behaviours, patients also perform cognitive neutralising behaviours, including "clean thinking" and mental rumination (Radomsky, Rachman et al. 2013, Coughtrey, Shafran et al. 2014, Coughtrey, Shafran et al. 2014). Recent case studies have indicated that individuals may turn to self-harm, substance misuse or injecting themselves with cleaning agents such as bleach, in an attempt to cleanse their insides. In relation to ERP, these cognitive neutralising behaviours are much more difficult to prevent. Even if the therapist asks their patients to not perform these internal neutralising behaviours, it will probably make the situation worse. It is much easier for an individual to avoid a certain behaviour rather than avoiding a certain cognition. If a person is asked to not think about a troubling memory, it will probably prime it. Here, self-harm would serve as a distraction so the individual can focus on the physical pain instead of the feelings of internal dirtiness, even for just a short time.

Previous experimental studies

Although MC is a relatively new concept within clinical psychology, it has generated significant research in the last decade. Most of this research uses the 'dirty kiss paradigm' (Fairbrother, Newth et al. 2005, Rachman, Radomsky et al. 2012, Radomsky, Rachman et al. 2013). The strategy is for participants to imagine scenarios where someone inappropriately kisses them in a sexual way. The researchers then measure participants' reactions including feelings of dirtiness after imagining such scenarios.

Fairbrother completed the original 'dirty kiss' study in 2005 with 121 female students who had no history of OCD or MC (Fairbrother, Newth et al. 2005). In this study, the participants were divided into two groups; the first group of

individuals had a scenario where, whilst at a party, they shared a consensual kiss with a man who was described as attractive. The second group of participants had a similar scenario with the modification that a man who was described as 'dirty' forced himself onto the individual, so the kiss was non-consensual (Fairbrother, Newth et al. 2005). It is important to note here that this description of the perpetrator has been varied in numerous studies to portray him to be more dirty, to smell, or to be more immoral, in order to see whether contamination scores increased (Fairbrother, Newth et al. 2005, Rachman 2007, Cougle, Lee et al. 2008).

Typical findings are that participants in the consensual group do not score highly in terms of contamination, although a few report minor feelings of betrayal due to having a boyfriend (Fairbrother, Newth et al. 2005). However, the researchers found a significant difference in that participants in the non-consensual kiss condition reported feeling much more dirty or unclean. Further, participants reported feeling more dirty internally and externally as well as in a non-physical form, compared to those individuals in the control group (Fairbrother, Newth et al. 2005). Fairbrother and colleagues found that individuals were less likely to drink from the kisser's glass, eat from the kisser's plate, and accept a drink from the kisser if they were in the non-consensual group.

In terms of neutralising behaviour, seventy of the hundred and twenty one participants accepted a glass of water from the experimenter and seven participants (six from the non-consensual group) reported that they drank all the water to wash away feelings of pollution from their mouth, and six other individuals (from the non-consensual group) reported drinking alleviated tension and stress caused by the study (Fairbrother, Newth et al. 2005). Furthermore, twenty five participants used the wash-room to physically wash their hands, and two of these individuals admitted that this was to counteract the pollution (Fairbrother, Newth et al. 2005). Even when this study has been replicated, the paradigm is effective in demonstrating that MC can be provoked in individuals who do not have OCD or contamination fears, through imagining an immoral act (Fairbrother, Newth et al. 2005, Rachman 2007, Rachman, Radomsky et al. 2012).

These studies however, do share an important factor; individuals are imagining a physical form of violation. This might suggest that participants are actually imagining a combination of both CC (bodily fluids) and MC (violation) at the same time. Researchers have sought to adjust the dirty kiss paradigm to avoid any physical elements. In a recent study, researchers have used a 'theft' as the violator rather than a non-consensual kiss (Millar, Salkovskis et al. 2016). In this study, the participant is asked to imagine that an item of sentimental value is stolen, and in one condition the perpetrator is a stranger, and in another, the item is stolen by a trusted friend. Surprisingly, imagining having a sentimental item stolen did not elicit feelings of MC in the same way the dirty kiss did (Millar, Salkovskis et al. 2016). It is important to note here that this is the first attempt at using the dirty kiss paradigm without a physical element, and this focussed solely on the betrayal

element. The author believes that MC may have been evoked if the researchers included aspects that challenged their self-perceptions, or degradation. The experiment does suggest that when the physical element was removed (the kiss), the experience of betrayal is not sufficient at producing MC alone.

Clearly, there has been a need to produce experimental evidence that MC can indeed be provoked without the existence of a physical component. Zhong and colleagues aimed to produce four experiments that investigated MC without the physical component (Zhong and Liljenquist 2006). In their publication, the researchers briefly discuss four distinctly different experiments to investigate the relationship between moral purity, contamination and washing. Most of the experiments revolved around participants recalling an ethical or unethical memory.

In this first experiment, participants had to perform word completion tasks after recording an ethical or unethical memory (Zhong and Liljenquist 2006). The individuals were presented with letter strings such as "W_ _ H", "SH_ _ _ R", "S_ _ P", and were asked to fill in the blanks to create a word. The researchers found that those participants who recalled an unethical memory were more likely to create words that were related to cleansing. For example, "wash", "shower", or "soap". Participants who recalled ethical memories created words including, "wish", "shaker", and "step" (Zhong and Liljenquist 2006). Similarly, in the third experiment, instead of completing the word completion tasks participants were offered either a pencil or an antibacterial wipe. As expected, those individuals who recalled unethical tasks selected the wipe (Zhong and Liljenquist 2006). Both experiments suggest that if an individual recalls a memory that includes immorality to some degree, they are likely to feel dirty and have urges to wash.

The second experiment was completely different, as the researchers asked the participants to re-write an ethical (helping a co-worker) or unethical (sabotaging a co-worker) story (Zhong and Liljenquist 2006). Once they had completed the task, they were then asked to rate the attractiveness of several different items, including soap, toothpaste, disinfectant, batteries, post-it notes and chocolate bars. Again, those individuals who had completed a task related to immorality were more likely to show a bias towards the cleaning products compared to those who focussed on a moral situation (Zhong and Liljenquist 2006). Similar to the first two experiments, the findings of the third investigation supported the notion that immorality can be associated with feelings of dirtiness and urges to wash.

Finally, their fourth experiment focussed on whether immorality can cause individuals to perform more positive behaviours (Zhong and Liljenquist 2006). This research design revolves around the ideas of maintaining self-perceptions or self-completion (discussed in following chapters). The experiment then demonstrated that 74% of participants who recalled an unethical memory without the opportunity to cleanse volunteered to help in future research (Zhong and Liljenquist 2006). However, only 41% of participants who had the opportunity to wash with antibacterial wipes volunteered. Further, these participants also reported

emotions such as guilt, shame and embarrassment which are heavily associated with the theory of MC (Rachman 2004, Rachman 2006).

Although the research of Zhong & LilJenquist did highlight a strong relationship between immoral behaviour and feelings of dirtiness (Zhong and Liljenquist 2006), there is a lack of detail regarding the immoral memories that participants recalled. It would be interesting to explore whether types of immorality had more of an effect on feelings of contamination than others. Furthermore, it may be that all the participants recalled unethical incidences that involved physical acts. Although this research definitely adds a great deal of knowledge to the field of MC, there remain so many different variables in this specific area alone that require further research.

Perpetrators

In the research literature thus far the researchers have mostly focussed on the victims, how they were violated and subsequently developed MC. However, the cases of Lady Macbeth and Pontius Pilate suggest that the perpetrators of immoral acts may also develop feelings of MC. Evans and colleague found that individuals who commit violent crimes, whether their victims are either seriously injured or killed, 46% experienced intrusive memories and 6% developed PTSD as a result of their crimes (Evans, Ehlers et al. 2007). They added that these young offenders negatively appraised their violent behaviours and experienced feelings of self-blame.

Researchers have also redesigned the dirty kiss study so instead of imagining a non-consensual kiss as the victim, as in the original study (Fairbrother and Rachman 2004), male participants were asked to imagine they were the perpetrator of an non-consensual kiss with an unwilling young lady (Rachman, Radomsky et al. 2012). The researchers conducted 4 experiments where they changed various features such as the narrator's voice, the reaction of friends who witnessed the non-consensual kiss (ranging from slightly disgusted comments, to highly disgusted name calling "you jerk", disgusted looks, etc), increase in betrayal (in the third experiment the female victim was the participants' best friend's sister, participant denied the kiss, blaming the victim).

As expected, Rachman and colleagues found that in every condition, participants reported higher feelings of dirtiness if they had heard the non-consensual kiss recording (Rachman, Radomsky et al. 2012). As the researchers increased the levels of disgust (comments, name-calling, looks), more participants in the non-consensual condition had to wash and rinse their mouths out; an increase of 3 to 5 individuals, 25%. In the betrayal experiment, feelings of dirtiness were higher than compared to the previous two conditions, and 5 participants had to wash.

The idea that perpetrators can experience mental contamination raises more questions in terms of the theory of MC. What kind of acts are immoral enough to make the perpetrator feel dirty? Can an individual commit an immoral act by accident and still feel polluted? This also raises questions about morality and

obedience. If an individual is going to war, can they justify killing other individuals, or do they also feel contaminated. This may be related to post-traumatic stress disorder which has been discussed in the diagnostic dilemmas section of this chapter.

Phenomenology

MC seems to have a strong moral foundation which is likely to strongly relate to the personal and cultural values of the individual (Rachman 1994, Rachman 2004, Rachman 2006). The researcher hypothesises that MC can develop when an individual is either treated, or behaves in ways that is inconsistent with their morals and values; they feel dirty because they have been "treated like dirt". Some individuals do continue to indulge in neutralising behaviours (such as compulsive washing or a form of mental rumination) after the immoral incident has occurred. This is because MC can be triggered by reminders of the incident, even when the perpetrator (if the patient is the victim) or the victim (if the patient is the perpetrator) is no longer present (de Silva and Marks 1999, Gershuny, Baer et al. 2003, Fairbrother and Rachman 2004). For example, some individuals develop MC as a result of rape (de Silva and Marks 1999, Gershuny, Baer et al. 2003, Rachman 2006). Further, individuals with MC can continue their obsessions, and neutralising behaviours for months, even years after the attack; some seek help as a way of ending their obsessive cycle.

The researcher hypothesises that along with the moral component, MC may be related to an individual's self-perceptions. For example, in the above example, the rapist is clearly behaving in ways that are inconsistent with the victim's morals and values. But, instead of blaming the attacker, the victim may actually begin to reappraise their sense of self, to the extent that they conclude that they were deserving of the immoral treatment. Similarly, if an individual finds themselves behaving in an immoral manner, they also may re-evaluate their self-perceptions and also conclude that they are a 'nasty person'. If the patient comes to either of these conclusions, the idea of being a 'bad person' or even 'worthless', may cause the individual to start feeling dirty. It is important to note here that this hypothesis is related to Salkovskis' Cognitive Theory of OCD and the concept of an inflated sense of responsibility (discussed above), and it may be the way in which MC is connected to OCD (Salkovskis 1989, Salkovskis, Shafran et al. 1999).

Although there is a lack of research investigating the link between self-perceptions and MC, this concept may be related to the concept of self-completion (Wicklund and Gollwitzer 1981, Gollwitzer, Wicklund et al. 1982, Zhong and Liljenquist 2006). The idea is that an individual must behave in ways which maintain their self-image. For example, in order for a guitarist to continue playing guitar at a high standard, he must practise regularly. Similarly, if the guitarist makes a mistake during a performance, he must practise to prevent making the same mistake in future. The researcher believes that if the individual is anxious or prone to MC, as a result of the potential triggers highlighted later in this chapter, he may re-evaluate his self-perceptions rather than seek methods to counteract the present issue.

Finally, the researcher would like to highlight the concept of being "tainted" in relation to MC. The idea is that MC is an internal form of contamination, which cannot simply be washed away. Individuals who are hypothesised to feel tainted are typically the victims of an immoral act, rather than the perpetrator. The victim has to live feeling damaged or 'ruined' whether they are the ones that have behaved immorally or whether they are the victim. Further, this is an inescapable state because, once the immoral act has been performed, it is then part of the individual's history. In the rape example, the victim may feel tainted because they have been treated with such distain, and as a result, the perpetrator has now a connection with the victim for their lifetime. The feeling of being tainted or defiled in this way may also cause the victim to reappraise their broader views on their relationships with people and society, which may then cause avoidance behaviour, or complete withdrawal from their social and occupational life.

Violations

Rachman hypothesises that violations can cause an individual to become more susceptible to, or directly trigger feelings of internal dirtiness (Rachman 2004, Rachman 2006, Rachman 2010). Further, a person's morals and values, self-perceptions and feeling of becoming tainted can all arise during or after a person has been violated to some degree. However, an individual can experience physical violations, psychological violations or a combination of the two during a traumatic incident. It is important to note here, that the different forms of violations may cause different types of contamination fear.

Physical violations, by definition, include a physical component, and usually encompass abuse, rape and even torture. These incidences are typically associated with the development of post-traumatic stress disorder (PTSD) for example (Ehlers, Clark et al. 1998, Dunmore, Clark et al. 1999), but can also be related to OCD (de Silva and Marks 1999, Coughtrey, Shafran et al. 2012, Elliott and Radomsky 2013, Lee, Shafran et al. 2013). Due to the physical nature, this form of violation is more associated with CC, and neutralising behaviours such as compulsive washing can be effective in temporarily relieving the individual's anxiety (Salkovskis 1985, Salkovskis 1999, Wahl, Salkovskis et al. 2008, Berle, Starcevic et al. 2012).

Psychological violations on the other hand, are more directly related to MC due to their cognitive nature. This type of violation can also be associated with the physical attacks mentioned above, in relation to the dehumanisation that can occur. For example, victims of rape often feel 'defeated' (discussed later) because they are made to feel worthless, that nobody cares, and that they should just accept the mistreatment (Gilbert, Allan et al. 2002). As a result, the victims can develop feelings of MC, that can continue to be triggered months or years after the attack (Elliott and Radomsky 2013, Ishikawa, Kobori et al. 2013). Psychological violations can also include one's own behaviours. As mentioned above, if individuals behave in ways inconsistent with their morals and values, they can develop feelings of internal dirtiness; these perpetrators have almost violated

themselves by not complying with their moral system (Bandura 1991, Rachman, Radomsky et al. 2012).

However, as with most things relating to human behaviour, nothing is black and white. Violations can overlap in most incidences; rape can be as much a physical violation as a psychological violation. This can be seen in patients who struggle with seeking to understand the attack many years later. Similarly, it is important to emphasise here the fact that the two forms of contamination can overlap too. A physical form of contamination may be converted into feelings of MC if a patient becomes contaminated simply by recalling the physical incident. Even though the dirty kiss studies appear to validate the betrayal theory of MC (Fairbrother, Newth et al. 2005), it has a key weakness because the participants are imagining a physical act, the non-consensual kiss. This experiment clearly demonstrates that individuals can feel dirty without a physical interaction. However, it also demonstrates that CC and MC can overlap greatly. This author considers that contamination in some instances may begin in the form of CC, but the simple recollection or imagining of such an incident may actually cause the individual to feel internally dirty, which would then be considered MC. More research is needed to investigate how these two forms of contamination interact, whether there are any indicators that one form can provoke the other, and whether or not there are any preventative measures that can be put in place in the therapy setting in an attempt to avoid the second form of dirtiness from being triggered.

Sub-categories of mental contamination

As with CC, there are subtle variations within the concept of MC, and Rachman identified three sub-categories: mind germs, morphing and self-contamination (Rachman 1994, Rachman 2004, Rachman 2006). Morphing is a symptom where the individual feels distressed because they believe they can partially or fully transform into another person who the individual sees as negative in some way. For example, a patient reported feeling anxious when he saw people who looked like the boy who bullied him because he was scared he would turn into that person (Rachman 1994, Rachman 2004, Rachman 2006). “Mind germs” is similar in that individuals fear they can contract the undesirable characteristics through the air if they are in close proximity with a person who they deem negative (Rachman 1994, Rachman 2004, Rachman 2006). If the patient had fears of mind germs rather than morphing, he probably would have been more concerned with catching ‘bullying’ or ‘nasty’ germs, which seems less extreme then completely transforming into a person with undesirable character (Rachman 1994, Rachman 2004, Rachman 2006). It is important to note here that the factors that determine the features of an undesirable character are dependant on the person’s culture, as well as their morals and values.

Finally, Rachman discusses self-contamination as another sub-category of MC (Rachman 1994, Rachman 2004, Rachman 2006). A great deal of research (as will be discussed in chapter 3) has focussed on MC in relation to the patient being considered the victim (Fairbrother and Rachman 2004, Fairbrother, Newth et al.

2005, Rachman 2010), but there are incidences of MC that revolve around one's own behaviour (Rachman 1994, Rachman 2004, Rachman 2006, Rachman, Radomsky et al. 2012). Self-contamination may occur in instances where one's own behaviours, urges, impulses, or even cognition can cause an individual to feel dirty, triggering neutralising behaviours (Rachman 1994, Rachman 2004, Rachman 2006). The researcher hypothesises that this may be related to a person's self-perceptions, morals and values. A person may begin to re-evaluate the ways in which they perceive themselves after behaving in ways that they deem unacceptable. As a result, they may develop feelings of dirtiness and begin compulsive behaviours after concluding they are a 'bad person'

Precursors and triggers of Mental Contamination

It has been hypothesised that particular experiences or behaviours have the potential to trigger MC through mnestic associations. The hypothesised precursors and triggers are described in detail in Chapter 3. In this section, the researcher aims to briefly highlight the main concepts that may cause an individual to develop MC, or become significantly more susceptible to feelings of internal dirtiness.

Obsessive-compulsive disorder - The researcher hypothesises OCD as one of the key factors that may play a role in the development of or susceptibility to the development of MC. Patients with OCD will already show obsessive and compulsive behaviours, with an inflated sense of responsibility (Salkovskis 1985, Shafran 1997, Radomsky and Rachman 1999, Salkovskis 1999). Further, the individual may also have pre-existing contamination fears; already suffering with CC. There is also a possibility that some people may experience clinical levels of MC without a diagnosis because the concept is so new and has not been recognised, or because CC has been diagnosed instead due to the similarity. In which case, MC may be diagnosed later during therapy after revelations relating to patient history or symptomology.

Bullying - The researcher believes there could be two potential relationships with bullying: bullying could act as a direct and specific trigger; or bullying as a general, non-specific stressor could cause an individual to become more vulnerable or susceptible to mental health problems. Some research has highlighted links between mood disorders, generalised anxiety disorder (GAD), body dysmorphic disorder (BDD), eating disorders and social anxiety (Kumpulainen, Räsänen et al. 1998, Kaltiala-Heino, Rimpelä et al. 1999, Kaltiala-Heino, Rimpelä et al. 2000, Berguno, Leroux et al. 2004, Blood and Blood 2004, Griffiths, Wolke et al. 2006, Wolke and Sapouna 2008, Cooper-Hobson and Jaffe 2009, Stellwagen and Kerig 2012). The researcher hypothesises that incidents of betrayal, defeat, degradation and defilement, and disgust, all of which can occur during bullying, are both generally and specifically related to the development of MC.

Betrayal - One of the most highly researched concepts in relation to MC is betrayal (Fairbrother and Rachman 2004, Rachman 2004, Fairbrother, Newth et al. 2005,

Rachman 2006, Herba and Rachman 2007, Elliott and Radomsky 2009, Radomsky and Elliott 2009, Rachman 2010, Coughtrey, Shafran et al. 2012, Elliott and Radomsky 2012, Rachman, Radomsky et al. 2012, Warnock-Parkes, Salkovskis et al. 2012, Ishikawa, Kobori et al. 2013, Radomsky, Rachman et al. 2013). The idea revolves around the key components of MC, discussed at the beginning of this chapter. The researcher believes that each individual component could be enough to trigger MC individually after an incident containing betrayal. However, it may be more plausible to suggest that a combination of two or three of these concepts may manifest in the development of MC when associated with acts of betrayal.

Degradation - The researcher believes that degradation and humiliation, although similar, are distinctly different. Humiliation seems to revolve around embarrassment, whereas degradation is hypothesised to encompass an attack on the person's sense of self, which may cause the victim to re-evaluate the way in which they perceive themselves. Both are negative experiences that a person would prefer to avoid. Humiliation however, does not seem to provoke feelings of MC. Degradation has been associated with feelings of internal dirtiness (Ishikawa, Kobori et al. 2013, Coughtrey, Shafran et al. 2014). The concept seems to fit with the moral, self-perceptions and tainted components that seem so fundamental within the theory of MC as well as physical and psychological violations. However, the researcher does not believe it can be apparent in cases of self-contamination; incidences where one's own behaviours trigger MC.

Disgust - Disgust is an experience that has been associated with feelings of contamination for some time, due to its physical and cognitive nature (Cougle, Lee et al. 2008, Moretz and McKay 2008, Berle, Starcevic et al. 2012, Badour, Feldner et al. 2013). Typical forms of disgust are more associated with CC, whereas disgust sensitivity, propensity, and now the introduction of 'moral disgust' seem to be more directly related with MC.

Mental defeat - This is a concept which has not been associated with MC and OCD because of the neutralising behaviours involved with these disorders. Defeat is typically related to depression and post-traumatic stress disorder (PTSD) and causes the patient to feel dehumanised (Gilbert and Allan 1998, Gilbert, Allan et al. 2002). Patients seem to give up hope and almost accept the situation. The researcher proposes conditioned mental defeat; patients perform neutralising behaviours (mental or physical, discussed above) to avoid feeling defeated. Patients who are unable to perform neutralising behaviours may show symptoms of mental defeat as a result. The researcher believes this may have significant implications in the treatment process, and psychologists may need to focus on reappraising the situation before exposure and response prevention therapy (discussed later).

The author discusses these concepts in greater detail in chapter 3. It is important to note that the researcher hypothesises that there is a possibility that MC can develop as a result of an individual concept. However, there is a possibility that

these suggested triggers may overlap greatly, to the extent that a patient with OCD may experience bullying. As a consequence, they may feel degraded, betrayed and disgusted, resulting in mental defeat. The theory of MC does require considerable research to understand the complex concept of MC, both theoretically and clinically. The issue of triggers and overlapping experiences is one of the areas requiring investigation. It seems likely that there may be particular combinations of the concepts outlined above that are more likely to provoke MC, or trigger particular symptoms.

Neutralising behaviours

As with OCD, MC is characterised by both obsessive and compulsive behaviours. The typical form of contamination, CC, is characterised by compulsive washing, one of the most common neutralising behaviours reported in patients suffering with OCD (Salkovskis 1985, Salkovskis 1999, American Psychiatry Association 2000, Torres, Prince et al. 2006, Wahl, Salkovskis et al. 2008). Patients suffering from CC can get temporary relief from anxiety and distress by engaging in washing rituals (described in greater detail in Chapter 2) because the contaminated part of the body can be readily located and therefore directly cleansed. However, with MC, the dirtiness is internal, so the contaminated area cannot be localised or accessed. As a result, compulsive washing is typically ineffective (Rachman 2004, Rachman 2006, Herba and Rachman 2007, Coughtrey, Shafran et al. 2012).

Patients do report engaging in compulsive washing which is often aimed at the entire body; some individuals have multiple showers with boiling water and report the common phrase “look clean, but feel dirty” (Rachman 2004, Rachman 2006). Others use self-harm and drinking or injecting their body with cleaning agents as a means of temporary relief. There is limited research into the effects of physical washing on MC, although Ishikawa and colleagues have made an attempt (Ishikawa, Kobori et al. 2014). The researchers did not yield any significant differences. However, the research design in this experiment is problematic; half the participants were asked to wash even if the individual did not feel compelled to clean. Further, their conclusion suggests that physical washing can be effective at reducing feelings of MC even though this statement was followed by the suggestion that compulsive washing is only as effective as simply waiting 5 minutes whilst doing nothing (Ishikawa, Kobori et al. 2014). This would suggest that MC reduction was probably a result of a form of decay, rather than the physical washing.

The researcher believes that some patients with MC may engage in cognitive neutralising behaviours; case studies now suggest that this may indeed be true (Elliott and Radomsky 2013, Coughtrey, Shafran et al. 2014). Some cognitive neutralising behaviour can revolve around having clean or positive thoughts, especially when doing certain activities. The task may have to be repeated if a negative thought intrudes before it has been completed. Alternatively, some individuals may have to repeat a clean thought a particular number of times to relieve their anxiety temporarily. Mental neutralising behaviour is clearly an area within MC that would benefit from empirical research. Not only would diagnosis

become more accurate if clinicians were aware of all the compulsive behaviours associated with MC, but it may also ultimately improve the effectiveness of treatment by gaining an increased understanding of the behaviour.

Conclusion

There are a great number of ideas and theories in relation to mental contamination, revolving around symptomology, morality, betrayal etc, without any real concrete basis. Creative studies like the dirty kiss paradigm (Fairbrother, Newth et al. 2005) and other empirical research support the existence of MC and important characteristics, but at present, we are unclear on so many fundamental elements. This research programme aims to focus on potential causes of MC. The author identifies bullying as a traumatic experience that may provoke, or cause a vulnerability to MC. In chapter 2 the researcher will outline bullying, and how it may fit within the framework of MC.

Chapter 2 – Bullying

Introduction

Bullying, the main focus of the present thesis, is one of a number of adverse life events or longer-term circumstances (including trauma, abuse and neglect) which can lead to longer term mental health problems in those vulnerable to it. It is proposed here that bullying, in addition to being a general stressor, may have relatively specific links to MC in those who react in particular ways, discussed in chapter 1. Before considering these possible mechanisms we will consider what is known about bullying both in general and in terms of its impact on mental health.

Bullying is particularly likely to be experienced during childhood, and the author believes that at times it may be traumatic enough to be related to the development of OCD and MC. Fekkes, Pijpers, & Verloove-Vanhorick (2004) defines bullying as being "exposed repeatedly and over time, to negative actions on the part of one or more students" (Fekkes, Pijpers et al. 2005). Bullying is defined as being always deliberate, the actions of an individual are aimed to intentionally hurt another, either physically or psychologically. The literature suggests that many children experience bullying at some point during their school life. Some report that between 5-15% of primary school children and 3-10% of adolescents in secondary schools experience bullying at some point (Kaltiala-Heino, Rimpelä et al. 2000), whereas other researchers go as far as saying that up to 46% of children will experience bullying at some point, and up to the 30% of children will actually become bullies themselves (Fekkes, Pijpers et al. 2005).

Bullying can have a huge impact on individuals during adulthood (Slee 1994, Craig 1998, Baldry 2004, Morrison 2006). Although it is not a large area of research, some individuals have related bullying to the development of psychological disorders later in life. For example, if a child is bullied due to their appearance, for being overweight, weak, or unattractive, there is evidence that some individuals can later develop body dysmorphic disorder (BDD) (Veale 2004, Veale 2004, Wolke and Sapouna 2008). For example, Veale (2004a) reported that many body builders exercise and work out so intensely at the gym due to the criticisms made by bullies at a young age (Veale 2004, Veale 2004). Walke and Sapouna (2008) also highlight that many of their case studies of patients with BDD also report experiences of appearance-related bullying (Veale, 2004a; Veale, 2004b; Walke and Sapouna 2008).

Bullying has also been related to the development of other anxiety disorders and depression in later years (Craig 1998, Kaltiala-Heino, Rimpelä et al. 1999, Baldry 2004, Fekkes, Pijpers et al. 2005). As will be discussed later, depression and anxiety may be issues that cause a child to become a target of bullying, but the experience of being constantly teased during a school day can also precipitate anxiety and depression (McCabe, Antony et al. 2003, Morrison 2006). In general, the experience of bullying can exacerbate a child's anxiety and, to a certain degree, depression (Olweus 1996, Craig 1998, Kaltiala-Heino, Rimpelä et al.

1999, Kaltiala-Heino, Rimpelä et al. 2000, McCabe, Antony et al. 2003). Some researchers believe that the relationship between bullying and anxiety becomes a vicious cycle in that, the more anxious a child becomes, the more often the child is a target of bullying, which subsequently results in increased anxiety (Silverman, La Greca et al. 1995, Kumpulainen, Räsänen et al. 1998, Roth, Coles et al. 2002). The consequences of victimisation often depend on the type of bullying that a child has experienced, as there are so many different ways that a child can be assaulted.

Types of Bullying

There are many different forms of bullying that will affect the victim in different ways (Graham and Juvonen 1998, Fekkes, Pijpers et al. 2005). For example, it is specifically appearance-related bullying that has been associated with BDD (Veale 2004, Wolke and Sapouna 2008). The typical physical bullying can involve being punched, kicked, pushed or even being the target of thrown objects, which is often associated with boys (Crick and Grotpeter 1995, Glover, Gough et al. 2000, Crick and Nelson 2002, Fekkes, Pijpers et al. 2005). According to Glover and colleagues, on the rare occasions where girls do engage in physical attacks, these incidents can be more serious than when boys fight (Glover, Gough et al. 2000). This form of victimisation will almost certainly result in physical harm, but if such attacks occur in public locations, such as the playground, it can also have psychological effects, being humiliated in front of a peer group. A result of public humiliation may be a reduction in the child's self-esteem, or the child may struggle with peer relationships (Crick and Nelson 2002, Janssen, Craig et al. 2004, Fekkes, Pijpers et al. 2005, Veenstra, Lindenberg et al. 2010). Childhood is often a period where most individuals attempt to make friends and seek acceptance from as many other children as possible, a task hard enough without public humiliation.

During childhood/adolescence, Glover, Gough, Johnson & Cartwright (2000) highlight the importance of opportunistic victimisation. Psychological bullying (discussed next), can occur in most environments due to its subtle nature (Crick and Nelson 2002). Physical bullying in boys on the other hand is almost restricted to the playground where children have much less supervision, and the bullies are confident that they can abuse others, whilst avoiding discipline from teachers or parents (Crick and Grotpeter 1995, Glover, Gough et al. 2000, Crick and Nelson 2002).

Girls are shown to perform much more psychological forms of bullying, rarely resulting in physical assault (Crick and Grotpeter 1995, Graham and Juvonen 1998, Glover, Gough et al. 2000, Crick and Nelson 2002, Smith, Cowie et al. 2002, Fekkes, Pijpers et al. 2005). Female bullies are more likely than males to spread rumours, ignore the victim, encourage other members of the peer group to reject the victim, verbal bullying, encourage name calling and develop negative nicknames for the particular child (Crick and Grotpeter 1995, Craig 1998, Glover, Gough et al. 2000, Crick and Nelson 2002, Smith, Cowie et al. 2002, Fekkes, Pijpers et al. 2005). Although this form of bullying rarely results in physical

injury, the psychological impact on acceptance in the school environment and even on personal development could be considered more damaging (Crick and Grotpeter 1995, Crick and Nelson 2002, Smith, Cowie et al. 2002, Baldry 2004, Janssen, Craig et al. 2004).

The prominence of such psychological bullying alone has caused a great deal of research in this area. Crick and colleagues have termed this type of victimisation relational bullying, as the attacks are more focussed on affecting a child's relationship with the peer group as a whole, groups of students as well as friends (Crick and Grotpeter 1995, Crick and Nelson 2002). As mentioned above, this is typically female bullying behaviour and can cause the victim to feel extremely isolated (Olweus 1996, Veenstra, Lindenberg et al. 2005, Veenstra, Lindenberg et al. 2010). This form of victimisation is subtler than physical attacks so children can be targeted in all school environments, from the classroom to the playground (Crick and Grotpeter 1995, Glover, Gough et al. 2000, Crick and Nelson 2002). Although physical bullying clearly causes harm in terms of injuries and fear, relational bullying affects the way in which a child develops as all children require positive social interactions (Janssen, Craig et al. 2004).

Research does suggest that girls are much more likely to be the perpetrators of psychological bullying, but we may need to rethink this theory when the emergence of cyber-bullying is considered. Although emails and other forms of messaging may be thought of as another form of verbal bullying, there are significant instances where these attacks develop into psychological bullying.

Cyber bullying

In the modern day individuals interact with each other more and more via the internet and younger children can now easily access the online world (Mishna, Khoury-Kassabri et al. 2012). Whether this is good idea or not is up for debate, but the internet can have detrimental effects for children, their confidence, and social ability. There are parental controls but these are designed to moderate the types of websites available to children. This does not help monitor or block communications children receive on chat rooms, social media, or message applications on their smartphones or tablets.

Cyber bullying can be defined as communications over the internet with the intention of deliberately hurting and upsetting and individual (Erdur-Baker 2010). This type of victimisation takes the form of verbal bullying, inn that the perpetrators take to the online world to call the victim names, pick on them, and generally make fun at their expense. It can also take the form of psychological bullying, where the victim is ignored, has friends turned against them, and nasty rumours spread about them (Smith, Mahdavi et al. 2006, Dilmaç and Aydogan 2010, Erdur-Baker 2010, Chen, Ho et al. 2017, Kim, Colwell et al. 2017, Menesini, Zambuto et al. 2017). The consequences seem to be the same as normal bullying, victims struggle with low confidence and self-esteem, anxiety, depression, and potentially mental health difficulties (Kaltiala-Heino, Rimpelä et al. 1999, Kaltiala-Heino, Rimpelä et al. 2000, Camodeca, Goossens et al. 2002, Baldry 2004, De Wet

2005, Fekkes, Pijpers et al. 2005, Carter and Spencer 2006, Due, Damsgaard et al. 2009).

The key issue seems to be how easy it is. Individuals, whether they are the perpetrator or the victim, can access social media, chat rooms, instant messaging applications from where ever they can log in to wifi. The perpetrators often see the online world in a positive light and enthusiastically access these domains to interact and make new friends. Some of these individuals may find it difficult to male friends face-to-face and see electronic interactions as ideal, especially if they are on websites where they can chat about topics that they are particularly interested in (Smith, Mahdavi et al. 2006, Erdur-Baker 2010, Chen, Ho et al. 2017).

On the other hand, it is even easier for the bully. Many of these sites only require a screen name which can be changed easily, creating a sense of anonymity. This could make it mor difficult for the victim because they have to endure aggressive behaviour on their phones, in their own bedroom, and they don't know who the bully is. Further, the cyber bullies are sat behind the screen of their computer, tablet or phone, so not only can they not see the consequences of their nasty behaviour, they can create a more aggressive online persona and treat others in ways that wouldn't do if they were face-to-face (Smith, Mahdavi et al. 2006, Dilmaç and Aydogan 2010, Erdur-Baker 2010, Mishna, Khoury-Kassabri et al. 2012).

Targets & Perpetrators

Although the presence of bullying is relatively high (Kaltiala-Heino, Rimpelä et al. 2000, Fekkes, Pijpers et al. 2005), obviously not every child will become a bully, and equally, not every child will experience bullying. Many researchers have discussed the factors that may cause a child to develop into a bully or become the target for victimisation. By understanding the main factors involved, psychologists hope to develop more effective approaches and strategies for understanding and combating the effects of bullying.

It is important to understand how complex a person is; you cannot simply understand an individual on the basis of their gender, there are so many different features that construct a sense of self, giving bullies different targets for their attacks. Taking an intersectional approach enables us to look beyond gender, and realise race, sexual orientation and social class all create a sense of self (Butler 2015). Children seem to be extremely good at identifying these individual features, often using them as the target of their bullying.

There has only been one study in the literature looking at intersectionality and bullying, and the researchers identified weight, sexual orientation, ethnicity and colour as the four features they aimed to explore (Garnett, Masyn et al. 2014). The researchers found that weight was the most common form of bullying and individuals who were victimisaed due to being overweight scored higher in terms

of depression and had more suicidal thoughts (Garnett, Masyn et al. 2014). Weight problems seem to be a common topic of bullying and many studies have reported overweight children are considerably more likely to be victimised (Sweeting and West 2001, Berguno, Leroux et al. 2004, Janssen, Craig et al. 2004, Griffiths, Wolke et al. 2006).

Another aspect of a child's sense of self that is often targeted by bullies is their sexual orientation. Research suggests that gay or bi-sexual adolescents are bullied far more than their heterosexual peers (Rivers and Cowie 2006, Dunn, Clark et al. 2017, Sterzing, Gibbs et al. 2017). Whether its stereotypical views, negative beliefs, pure heterosexism, or just using words associated with homosexuality as derogatory insults to shout at others, sexuality is common in bullying (Rivers and Cowie 2006, Espelage and Swearer 2008, Dunn, Clark et al. 2017).

In terms of the perpetrator, bullies in general tend to have extrovert personalities (Dilmaç and Aydogan 2010), children who like to be the centre of attention, who demand a large circle of friends and who often exert a degree of control over the peer group (Batsche and Knoff 1994, Camodeca and Goossens 2005, Veenstra, Lindenberg et al. 2005, de Bruyn, Cillessen et al. 2010, Stellwagen and Kerig 2012). This is often the case in terms of the popular group of girls at school who aim to remain the most popular by belittling other girls in the peer group whom they may see as a threat.

For example, a recent case of a lady, known as K, experienced bullying from the 'popular kids' in her school. She shared the researcher's views that bullying may be involved, to some degree, in the development of OCD. K met with the researchers to discuss these views and share her experiences as a method of developing these ideas further (the case is described in full later). During the meeting, K indicated that the victimisation was orchestrated by the girls in her year, and believed that it was because she was 'different'. K dressed differently to the popular girls, read more complex books, and was generally interested in different things compared to the rest of the year. K believed that the bullying was targeted at these differences, for example the other children often took her book away from her, and made fun of her hairstyle. K's theory is consistent with the literature as many researchers find incidences of students being bullied for behaving differently (Sweeting and West 2001, Frisen, Jonsson et al. 2007, Swearer, Turner et al. 2008). It could be argued that the popular girls felt threatened by K's individuality and this is the reason why she was a target of bullying.

Personality type can also be involved in relation to children who become the targets of bullying. Typically, students with introverted personality types are often said to be shy and less outgoing than the other children in the peer group (Bradley and Hebert 1997, Maltby, Macaskill et al. 2010). These children are often quiet and more interested in reading books than participating in social activities, which may be viewed as 'weird' or 'different' by bullies (Sweeting and West 2001,

Woods and White 2005). As a result, these students make for easy targets for physical, verbal and psychological bullying. As mentioned above, it is usually the boys who target the introverted children as a way of expressing their power to the rest of the peer group (Stellwagen and Kerig 2012).

Although it is uncommon, children with extroverted personality types can also be the target for victimisation (Mairee 2005). K, the case mentioned above, could be considered an extrovert with her bubbly personality and the desire to get along with everyone in her peer group. In these instances of bullying, it is suggested that extroverted children try too hard to be accepted by peers or seen as too popular, and experience bullying as a result.

Not every extroverted child is going to become a bully during their school time so some researchers have begun to investigate other personality issues that may lead to bullying behaviours (Björkqvist, Osterman et al. 1994, Olweus 1996, Connolly and O'Moore 2003, Bollmer, Harris et al. 2006). Some researchers have focussed on the role of aggression in a bully's personality. The literature suggests that bullies are more likely to have aggressive personality types, positive attitudes to aggressive behaviours, or both (Björkqvist, Osterman et al. 1994, Connolly and O'Moore 2003, Camodeca and Goossens 2005, Bollmer, Harris et al. 2006, Björkqvist, Ekman et al. 2008). Others have added that domination also plays a role and that bullies have the desire to dominate other peers or even the whole peer group (Björkqvist, Osterman et al. 1994, Ferguson, San Miguel et al. 2007, Björkqvist, Ekman et al. 2008).

Although there is much empirical support for the suggestion of an aggressive and dominant personality, other researchers have suggested that the bully may also suffer from a lack of self-esteem (Andreou 2001, Björkqvist, Ekman et al. 2008). Typical students generate respect and popularity through competence at school or other skills, such as being good at football or art (Björkqvist, Osterman et al. 1994). Some researchers have suggested that bullies may attempt to generate a positive self-image by making friendships and being seen as popular through bullying behaviours. These friendships may be other students who admire domination and aggression, or may develop friendships to avoid being targeted themselves (Baldry and Farrington 2000, Baldry 2004, Huseby 2006).

The idea of being different in the research area of bullying is extremely broad (Sweeting and West 2001, Frisen, Jonsson et al. 2007, Swearer, Turner et al. 2008). As with the case of K, bullies seemed to victimise her because she dressed differently, and had unique interests. However, other children can be classed as 'different' due to a disability or a vulnerability. Students with facial disfigurements are likely to endure taunting due to their appearance (Turner, Rumsey et al. 1998, Clarke 1999, Rumsey and Harcourt 2004, Lovegrove and Rumsey 2005, Griffiths, Wolke et al. 2006). Similarly, children who suffer with anxiety or depression can also be the target of bullying (Silverman, La Greca et al. 1995, Craig 1998, Kaltiala-Heino, Rimpelä et al. 1999, Woods and Wolke 2004, Kim, Leventhal et

al. 2006). These children typically resemble students with an introvert personality, in that they are often quiet and seek privacy rather than social interaction. Children who are highly anxious in particular may also have other difficulties, for example a stutter or a facial tic which can be exacerbated in environments that provoke stress (Langevin, Bortnick et al. 1998, Blood and Blood 2004, Zinner 2004, Carter and Spencer 2006). These behaviours are likely to attract the attention of peers and can lead to bullying. A vicious cycle can then develop because the more an anxious child is bullied, anxiety levels increase and behaviour such as a stutter can become more pronounced. This can then cause more bullying, and the cycle continues (Batsche and Knoff 1994).

Similar cycles can be identified in children who become bullies. For example, if a child bullies a peer and receives their lunch money, that in itself becomes positive reinforcement which can cause the bully to repeat the aggressive behaviour (O'Connell, Pepler et al. 1999, Mahady Wilton, Craig et al. 2001). Similarly, if a bully attacks a vulnerable student and then receives positive attention from other peers, for example the acquisition of new friendships, this student may continue the bullying behaviour to seek more rewards. Researchers believe that actually a large proportion of this positive feedback by peers is an attempt of other students avoiding becoming a victim themselves. By befriending a bully and praising their antisocial behaviour, a peer is more likely to become a friend than an enemy and not be victimised (O'Connell, Pepler et al. 1999, Mahady Wilton, Craig et al. 2001, Fekkes, Pijpers et al. 2005).

The idea that students befriend a bully to avoid becoming victimised themselves is associated with the state of mind 'bully or be bullied' (Hymel and Swearer Napolitano 2008). This is especially important considering the fact that often bullies conduct aggressive or anti-social behaviours in groups (Baldry 2004, Huseby 2006). In the case of K, she reported being bullied by a group of popular girls, a common situation that some students find themselves in at school. It may be that the core of members of the group were indeed friends, with the other members of the group conforming and participating in the bullying purely to avoid being bullied themselves. It could be that the two 'main' characters in the group are actually two individual bullies that became friends for the same reason. Gradually their friendship group may have expanded because their peers opted to conform rather than be bullied themselves.

Another area where vicious cycles can develop is instances of a victim becoming a bully; these students have been labelled 'bully/victims' (Glover, Gough et al. 2000, Hanish and Guerra 2004, Fekkes, Pijpers et al. 2005, Veenstra, Lindenberg et al. 2005). About half of the children who bully report being bullied themselves (Veenstra, Lindenberg et al. 2005). If a child experiences bullying on a number of occasions, they may get to a point where they fight back and almost bully the bully (Camodeca, Goossens et al. 2002, Swearer, Turner et al. 2008). As a result, this child may receive many different types of positive reward from preventing future bullying to the development of new friendships and gaining respect from other

peers. Some students may stop at this point, satisfied that they are no longer a target of victimisation. Other students may seek further gratification by continuing to bully the same student, or even other peers in the attempt to increase their status in the school environment. In these situations it may be considered that the bullying behaviour is actually a defence mechanism to avoid future bullying themselves (Henry and Sanders 2007, Hymel and Swearer Napolitano 2008). As with positive reinforcement, if these mechanisms are seen to be effective, they are likely to continue being performed.

Social class has also been found to be relevant (Sweeting and West 2001, Gillies 2005, Nation, Vieno et al. 2007, Sentse, Scholte et al. 2007, Caravita, Di Blasio et al. 2009, Due, Damsgaard et al. 2009). It is relatively common that victims of bullying come from poor households. For example, if the parent/s are struggling financially, they may send their children to school in dirty clothes, or clothes that are too small. Other students may see this as a reason to bully the child, or treat the child as a type of weapon towards other peers for fun; forcing a friend to sit by the 'smelly kid' on the school bus (Percy-Smith and Matthews 2001). Equally, if parents are uneducated, their children may be victimised for having 'stupid' parents, or for being stupid themselves. This may cause the victim to feel worthless, and may feel lower in the peer group.

Finally, parental styles have also been associated with a child becoming a bully, as well as being a victim of bullying (Baldry and Farrington 2000, Dake, Price et al. 2003, Sachs-Ericsson, Verona et al. 2006). In terms of the potential causes for a child developing into a bully, the literature suggests that these students typically have authoritarian parents, who have strict rules (Baldry 2003, Dake, Price et al. 2003, Ahmed and Braithwaite 2004). Having authoritarian parents can cause a child to become quite narcissistic, which may explain why bullies are often the popular girls who desire attention or boys who show off in front of peers (Ahmed and Braithwaite 2005, de Bruyn and Cillessen 2006, de Bruyn, Cillessen et al. 2010). These children are also more likely to experience physical, and sometimes extreme forms of punishment. It is important to note here that some experiences of punishment may be more random, rather than a consequence of unwanted behaviour (Olweus 1980, Connolly and O'Moore 2003, Odu and Paulina 2008, Portnoy 2008). The experiences of physical punishment can also be related to child abuse, neglect and rejection, which is also suggested as another factor that may cause bullying behaviours in children (Connolly and O'Moore 2003).

It may not be surprising that if a child experiences aggression in the home, they may imitate their parents and perform aggressive behaviours at school, in an environment that they can control (Nation, Vieno et al. 2007). Bandura has been a leading researcher for over fifty years investigating vicarious reinforcement; the way in which individuals learn by mimicking the behaviours of others (Bandura 1963, Bandura and Rosenthal 1966, Bandura 1971). Research has identified that a lack of a positive role model can also influence bullying behaviours (Flouri and Buchanan 2003). If a child witnesses their parents performing aggressive

behaviours to themselves or other individuals, they may see this as appropriate behaviour and therefore carry it out at school (Baldry 2003, Ahmed and Braithwaite 2004).

On the other hand, the way in which parents raise their children may also lead to victimisation at school. Researchers suggest that the lack of socialisation in children may cause them to become targets of bullying (Ladd and Ladd 1998, Dake, Price et al. 2003). For example, if parents demand a great deal from their child, and order them to return home to carry out certain chores, these children may not have sufficient time to build relationships with other peers in a social environment. Similarly, if a child is spending more time and has a closer relationship with the parent rather than peers at school, this can also lead to victimisation. This is more apparent in boys who have an intense relationship with their mother (Ladd and Ladd 1998, Dake, Price et al. 2003).

The role of the father figure has provoked significant investigations. Some research suggests a male character can cause the child to become a bully or a victim (Gordon 1937, Dake, Price et al. 2003, Flouri and Buchanan 2003, Pepler, Craig et al. 2006). Research also suggests that children are also less likely to be victimised if they have both a mother and father in the households (Dake, Price et al. 2003, Flouri and Buchanan 2003, Wolke, Woods et al. 2003, Griffiths, Wolke et al. 2006). However, recent investigations have focussed on the impact of same-sexed parents on the child's wellbeing (Patterson 1992, Clarke 2002, Wainright and Patterson 2006, Tasker and Patterson 2008). Research suggests there are no differences in victimisation, psychological wellbeing, support networks or common adolescent concern when comparing children with same-sex to opposite sex parenting (Wainright and Patterson 2006, Crowl, Ahn et al. 2008, Rivers, Poteat et al. 2008, Tasker and Patterson 2008). Indeed, the strength of the relationship between parents and child may be more important in relation to child outcomes compared to the gender or sexual orientation of the parent.

Communication between children and their parents has also been suggested to be important in the child's development (Spriggs, Iannotti et al. 2007, Walden and Beran 2010). In household where communication is a regular occurrence, the child is less likely to become a victim of bullying (Spriggs, Iannotti et al. 2007, Walden and Beran 2010). However, if a child lacks communication with parents, in situations of neglect for example, they are more likely to develop bullying behaviours, perhaps due to a lack of social skills (Dake, Price et al. 2003, Spriggs, Iannotti et al. 2007, Walden and Beran 2010).

Parents & Teachers

The parent plays a role in the prevention or combat of the bullying experience by their child. Once a student has become a victim of bullying, they have the decision to make of whether they inform an adult, be it a parent or a teacher, or attempt to resolve the issue without such support (Berguno, Leroux et al. 2004, Unnever and Cornell 2004, Fekkes, Pijpers et al. 2005, Fekkes, Pijpers et al. 2005). This is an

important decision for many reasons and has attracted a great deal of research by psychologists.

The decision whether to inform an adult, brings about the dilemma of whether the authoritative figure will ultimately help the student or whether they will actually make the bullying worse (Hunter, Boyle et al. 2004, Oliver and Candappa 2007). Fellow students may look at the decision as the student 'being weak' and unable to defend themselves, which may cause more bullying. Some students report that even if they tell some teachers they seem uninterested, they disbelieve the child, or the child is told to stop 'telling tales' and getting others into trouble (Glover, Gough et al. 2000). This obviously could discourage victims from seeking the support of adults. Similarly, the other students may see it as 'telling', deliberately trying to get them in trouble, albeit deserved (Glover, Gough et al. 2000, McDougall 2007, Oliver and Candappa 2007, Wilde 2008, Shore 2009). The victim may see this as an embarrassing avoidance measure, in particular when parents begin to get involved, as this can be extremely emotional and the situation can get out of hand.

However, adults in a child's life, whether they are teachers or parents, are there to support the child through life, including traumatic experiences such as bullying (Pepler, Craig et al. 1993, Konishi, Hymel et al. 2010). Although the primary job of a teacher is to educate students, they do have the responsibility to support the students throughout the school day. Equally, one of the main jobs as a parent is to protect the child at all costs, so in situations of bullying adults need to be informed, even if it is a hard decision to make. This is additionally important when many strategies or approaches, which are developed to reduce bullying, are based on a large part with adults' involvement. Teachers and parents are told to stress the importance of informing an adult to their students or children when enforcing effective bullying intervention strategies (Pepler, Craig et al. 1993, Glover, Gough et al. 2000, Pepler, Craig et al. 2006, McDougall 2007, Oliver and Candappa 2007).

There are situations in which the parent can make the situation worse for their child (Dake, Price et al. 2003, Desforges, Abouchaar et al. 2003). Direct interaction between the bully and the victim's parents can have negative consequences for the victim. Equally, in the heat of the moment this interaction may cause parents to be seen as themselves acting as bullies and make matters worse. There may be instances where the parent may inadvertently be seen to side with the bully. If a child returns home and informs his mother that other children are calling him fat, in which she agrees and suggests that the child should lose weight, not only can the relationship between the two break down, but the child can feel extremely betrayed by his parent (Hodges, Malone et al. 1997, Crick and Nelson 2002, Koehler and Gershoff 2003, Rachman 2010). In this situation the child is obviously seeking support and guidance from his mother so the fact that she seems to be agreeing with the bully can be extremely damaging to the child's self-esteem and their relationship with their parent. In terms of betrayal, the sense

becomes more intense in situations where you have more expectations in the second person; the more a person is trusted, the more intense the betrayal (Koehler and Gershoff 2003, Rachman 2010). So if a parent is being seen to be conducive with the bully, the sense of betrayal is likely to be extreme.

Similarly, informing a teacher or a member of staff at the school can also have negative consequences and make the situation worse. In the case of K, she had an incident where during group work she was actually paired with two of her bullies when working in threes. This in itself made the lesson much more difficult for K, but this particular teacher was aware of her situation, and still grouped her with these two students. In this situation, K could have seen the teacher as encouraging the bullies, which not only had negative effects on K's lesson, it also may have exacerbated the bullies negative behaviour. There are other incidences where teachers at school may be aware of bullying situations but decide not to intervene, allowing the traumatic experiences to continue (Glover, Gough et al. 2000, Berguno, Leroux et al. 2004), or the teacher may actually be the bully (Whitted and Dupper 2008). In situations where the teacher fails to protect the victim from the bullies, feeling of betrayal may emerge (Koehler and Gershoff 2003, Rachman 2010). As with parents, the feelings of betrayal may be intense as teachers are seen as individuals who are responsible for protecting the students.

Peers

In the same way that victims are happy to decide whether or not to inform parents or teachers, they also have to decide whether or not it is worth telling friends and other members of the peer group. In many instances of bullying, the victim's friends are already aware of the attacks due to the public nature of the bullying or the fact that they too are victims themselves (Crick and Nelson 2002, Fekkes, Pijpers et al. 2005). It is common that students who share certain characteristics such as being overly anxious or having a disability of some type actually befriend each other. In these instances it is not a single student that the bullies target, it is the entire group of friends (Eslea, Menesini et al. 2004, Salmivalli 2010).

In the situation where the bullying is experienced in isolated locations such as the school bus, the victim has to decide whether to inform anyone. Depending on the nature of friendships, the student may have a close group of peers that he may opt to tell. One idea is that if students stick together, it becomes more difficult to be a target of bullying; especially where there is only one sole bully and the target is amongst a group of friends (Vreeman and Carroll 2007, Merrell, Gueldner et al. 2008, Ttofi and Farrington 2011). In these circumstances the victim can generate a great deal of support and security by informing their friends. Many bullying prevention strategies work on the basis of peers being aware of the bullying and help protect the particular student. In other situations research suggests that the victim should inform the entire peer group, even if the students are not considered close friends (Pepler, Craig et al. 1993, O'Connell, Pepler et al. 1999, Salmivalli, Kaukiainen et al. 2004, Smith, Mahdavi et al. 2006). The notion is that most students would want to eradicate bullying and so may take the opportunity to

extinguish the bully.

However, there are instances where informing friends and peers may have negative consequences. A common way of avoiding being the target is for students to actually join in with the bullying (Crick and Nelson 2002, Mishna, Wiener et al. 2008, Rose, Monda-Amaya et al. 2011). For example, if friends find out a particular child is being targeted, they may also begin bullying that victim to ensure the initial bully looks upon them as an ally rather than another potential target. In more subtle cases, friends may distance themselves from the target as a method of avoiding the bully (Henderson and Hymel 2003, Veenstra, Lindenberg et al. 2005). Alternatively, the victim may fear embarrassment and humiliation and therefore avoid telling anyone, especially members of their peer group (Glover, Gough et al. 2000, Sachs and Chu 2002, Hamiwka, Yu et al. 2009). Furthermore, friends may turn and begin bullying a child as they see it as an opportunity to improve their status amongst peers.

As mentioned above, bullying can often be associated with feelings of betrayal (Craig 1998, Crick and Nelson 2002, Athanasiades and Deliyanni,ÄêKouimtzis 2010). The victim may feel betrayed and humiliated if he does inform friends and they fail to show support and withdraw their friendship (Crick and Nelson 2002, Henderson and Hymel 2003, Ringrose 2008). If a child is bullied by a friend, a person in which he expects a degree of loyalty, and of whom he trusts, feelings of betrayal can be extreme (Crick and Nelson 2002, Mishna, Wiener et al. 2008). The victim may begin questioning themselves and conclude they deserve to be bullied.

Prevention

Preventing bullying is critical for school children for avoiding unnecessary distress and potential mental health difficulties. The government claim ‘some’ forms of bullying are actually illegal and should be reported directly to the police (2015). Here are the criteria for an act of bullying to be deemed as illegal:

- Violence or assault
- Theft
- Repeated harassment or intimidation, for example name calling, threats and abusive phone calls, emails or text messages
- Hate crimes

Some could argue every form of bullying can fit in one of the above points, so maybe the police or other authorities should be more involved. The government also provide a list of documents advising head-teachers, teachers and other members of staff the best methods for tackling both bullying and cyber bullying. These documents often remind the reader of the Education ad Inspections Act 2006, which states every state school must prevent all forms of bullying, and the Equality Act 2010, covering everyone regardless of age, gender, disability, race, sexual orientation, etc. (Bullying At School, 2015). Finally, the government have made it a legal requirement that every school must have policies on bullying (Preventing Bullying, 2015).

Schools have the freedom to develop their own policies on bullying as well as procedures and strategies in terms of bullying prevention, reporting bullying, and stopping the

victimisation. School policies differ but the following strategies seem to be effective:

- No blame support groups – the victims explain how they feel or how they are affected by the bullying in the form of a poem or story and then it is discussed in a group containing the bullies and bystanders. As there is no blame, the idea is the bullies are more likely to get involved in resolving the issues and bystanders will be more likely to intervene after hearing how the victims feel (BullyingUK).
- Counselling/mediation – students involved in the victimisation discuss the situation with a mediator to resolve the situation. This method is more effective when the bullying involves friends (BullyingUK).
- Circle time – all students from a particular class or year group sit in a circle and take part in a fun activity for a short period, then each pupil has the opportunity to discuss something bothering them without being interrupted or laughed at. The victim may feel embarrassed or fear humiliation and opt to stay quiet (BullyingUK).
- Peer support programmes – students, usually strong in character and desire extra responsibility are trained to work with sad or distressed peers. Then, victims of bullying can seek out peers of a similar age for support rather than teachers or parents. For anonymity, these supportive students may have pigeon holes so the victims can seek support without any face-to-face interaction. The supportive team can give support and contact relevant teachers if necessary (BullyingUK).
- A 'telling school' – the students learn a philosophy that telling a teacher about an unacceptable behaviour is not a bad thing, it is actually a way of protecting peers. As a result, if the victim does not reach out for support, a bystander can alert teachers of incidents of bullying (BullyingUK).

Some of these techniques can be extremely effective at preventing bullying, creating a support network, and potentially help the victims make new friends. That being said, these techniques rely on consistency, and teachers having the time and inclination to help victims of bullying, which isn't always the case (Berguno, Leroux et al. 2004, Nation, Vieno et al. 2007, Whitted and Dupper 2008, Sylvester 2011).

Summary

With the increase in reports of bullying at school, it is hardly surprising that psychologists have generated so many empirical investigations in the area. The research ranges from types of bullying (physical, verbal, psychological, cyber), the reactions of others (family, friends, teachers), to the consequences of being bullied (depression, anxiety, psychological disorders). Yet there is so much more research required. We need a better understanding of efficient preventative measures, it should be much easier for victims of bullying not only to seek effective help without judgement, but procedures should be in place for these individuals to escape the bullying immediately, and psychologists need more detailed evidence to how bullying might interact with different psychological disorders.

Case Study: K

The idea to link OCD with bullying was reinforced during a meeting with an individual who suffered with OCD from the age of 11 years, she will be referred to as K. K was bullied during school between the ages of about eight to eleven years for being different. Interestingly, during a period when her bullying had stopped, the "queen bully" actually sought friendship with her. OCD was triggered when

her sister returned home from school with head lice and K had to be checked to ensure that she did not have them too. Although her hair was clean, K developed feelings of dirtiness, and became fearful that her peers at school would find out and the bullying would start again. Both K's feelings of dirtiness and fears of victimisation were so intense that she began washing her hands compulsively. The compulsive hand washing became her neutralising behaviour and alleviated her anxiety to some extent, albeit only temporarily. Unfortunately, K was the target of bullies for a second time, experiences that K had to battle with for a large proportion of her childhood.

Rationale behind the relationship between bullying and OCD & MC

At this stage, bullying has not been specifically linked with OCD, and K told her story and expressed her feelings when she found out about my research. MC has been strongly related to morality and the idea that if a person is treated in ways that conflict with their moral system, the individual may develop feelings of internal dirtiness (see chapter 1). Negative feelings such as betrayal, degradation, shame, amongst others, have all been associated with MC. The author noted that most of these feelings, if not all of them, are often reported by victims of bullying. It seemed plausible to suggest the bullying could play a role in the development of MC, and possibly OCD.

In the next chapter, I will identify the key concepts of MC and explain how they may cause feelings of internal dirtiness, and how they may relate to experiences of bullying.

Chapter 3 - Concepts within Mental Contamination

Introduction

The experience of bullying can be conceptualised as an acute or chronic stressor or life event which allows us to place it in the context of Cognitive Theories of emotional problems. Specifically, being bullied would, in those vulnerable to its effects, be associated with a range of evaluative response including perceived actual or symbolic loss (as in depression) current or future threat/danger (as in anxiety) unfairness/violation of rules (as in anger) self-reproach/responsibility/blaming (as in guilt). Rachman and colleagues suggests that mental contamination is a complex emotional response linked to memories of past events, particularly but not necessarily exclusively those involving a perceived assault on one's morals, values, social self-concept and self perceptions. The types of self-evaluative responses hypothesised here to be linked to MC include Betrayal, Degradation and Violation, and Mental Defeat; these constructs are all discussed below.

MC is an internal experience of dirtiness, the concept is affected by many of the individual's cognitive systems and standards. The literature suggests that MC is linked to a person's moral values. These standards may become activated when appraising the behaviour of oneself or others (Rachman 1994, Fairbrother and Rachman 2004, Rachman 2004, Rachman 2006, Coughtrey, Shafran et al. 2012). An individual's morals and standards are associated with an extremely complex cognitive system (Bandura 1991, Bandura 1991, Blair 1995). Such a system would rely on the person's cultural background, the way in which he or she has been raised by parents, and other social norms that are appropriate during the individual's life (Hoffman and Saltzstein 1967, Kohlberg 1975, Bandura 1991, Smetana 1999, Fehr and Fischbacher 2004, Haidt and Joseph 2007). Morals to some individuals may be so integral that they almost define the person, whereas for others, morals may be neglected or even undeveloped (Bandura 1991, Bandura 1991, Blair 1995). We suggest that those individuals who are more sensitive towards moral reasoning may be more vulnerable to feelings of MC based on the view that violation of their moral code will be perceived as having contaminated them at the level of their self. Individuals who have high moral reasoning are more sensitive to morals and social expectations; having great respect for their own moral system (Walker 1984). For example, a false accusation that questions a person's morals may be enough to trigger neutralising behaviours in such individuals. The fundamental component seems to be that a vulnerable individual can internalise certain accusations and may even consider it an attack on the self. Instead of attempting to falsify the claims or blame the relevant party, the individual seems to take responsibility and begins to internalise the particular event. In this chapter, a person's self-perceptions, betrayal, degradation, disgust and self-defeat are discussed in relation to MC and OCD. The researcher has identified these areas as having the potential to cause an individual to become more susceptible, or to directly trigger the development of MC.

Self-perceptions

There is some consensus that an individual's morals and standards appear to be fundamental to the development of MC (Rachman 2004, Rachman 2006, Coughtrey, Shafran et al. 2012, Warnock-Parkes, Salkovskis et al. 2012). To feel dirty, you must have a concept of cleanliness. Similar to the cognitive theory of OCD, individuals appraise the behaviour of oneself and of others in concordance with the assumptions linked to their overall moral system (Salkovskis 1999, Salkovskis, Shafran et al. 1999, Elliott and Radomsky 2013, Ishikawa, Kobori et al. 2013). These appraisals seem to affect the individual's self-perceptions. When a person appraises their own immoral behaviour, they may be shocked by their own actions (Rachman, Radomsky et al. 2012). In that study, the researchers aim to explore MC in 'perpetrators'. As hypothesised, the individuals developed feelings of internal dirtiness along with guilt, disgust and shame as a result of their own 'imagined' behaviour. It is important to note here that the participants did not actually perform any immoral behaviours, they were asked to imagine scenarios where they were caught behaving immorally (Rachman, Radomsky et al. 2012).

It is plausible to suggest that during the study the 'perpetrator' may have begun reappraising their sense of self after performing imagined immoral behaviours (although this was not a variable investigated by the researchers). In situations where individuals do physically perform immoral behaviours or have immoral cognitions, the person's self-perception may actually change as a result. The individual can believe that they are a bad person if they are capable of such behaviour. Note that this may also extend to evaluation of their own thoughts, especially where thought action fusion is prominent. As a result, the individual may begin feeling dirty or tainted by their own acts, and may seek to counter these using neutralising behaviours. The researcher hypothesises that these appraisals occur in populations who have rigid and unduly strict moral reasoning, Individuals who frequently indulge in "immoral" behaviours may have re-appraised their action as belonging to a different moral code or may have already accepted the fact that they could be considered a 'bad person' within society and therefore there is no discordance between their self-image and their image within society.

The researcher also hypothesises that a victim of immoral behaviour may begin to reappraise their sense of self due to an inflated sense of responsibility. Again, this is similar to the cognitive theory of OCD in that sufferers take responsibility in situations where they are objectively not to blame (Salkovskis 1985, Salkovskis, Shafran et al. 1999). This role of responsibility was identified in the theory of MC where patients have assumed responsibility for situations where they could be objectively regarded as the victim (Rachman 2006, Rachman 2010). Rachman (2010) discusses a case study where a lady takes responsibility for her sexual abuse because her mother accused her of being 'overly friendly' (Rachman 2010). Although this was not investigated, the researcher believes that, as the victim took responsibility, she may have began re-appraising her sense of self and may even have suggested that she deserved the abuse (Rachman 2010). In another case, a woman begins to believe that she has a weak character and poor judgement in

people after her partner was found to be unfaithful (Rachman 2010). Although there is a lack of research in the role of self-perceptions in the development of MC, these two case studies suggest the theory does warrant an empirical investigation. A key perception in this context is that of betrayal, either as the "victim" or as the "perpetrator".

Betrayal

Betrayal is a complex emotion that has been linked with fears of MC (Fairbrother and Rachman 2004, Fairbrother, Newth et al. 2005, Cougle, Lee et al. 2008, Rachman 2010, Coughtrey, Shafran et al. 2011, Coughtrey, Shafran et al. 2012, Warnock-Parkes, Salkovskis et al. 2012). Rachman defined betrayal as "a sense of being harmed by the intentional action, or omissions, of a person who was assumed to be a trusted and loyal friend, relative, partner, colleague or companion" (Rachman 2010). Betrayal is usually a surprising and unexpected event because we typically have a trusting bond with the person who has betrayed us. In contrast, it is not normally considered betrayal if an "enemy" inflicts harm onto another person as it may be expected (Rachman 2010). It is important to note that there are many types of betrayal; experiences of infidelity, disloyalty, dishonesty, harmful disclosure of confidential information and the failure to offer expected assistance during significant times of need, which have all been associated with the development of MC and often overlap (Rachman 2010). For example, if an individual has developed MC subsequent to finding out about their partner's infidelity, dishonesty and disloyalty may also be reported. However, instances where individuals or entire communities feel betrayed by another person or institution are not seen to be related to fears of MC (Rachman 2010). This may reflect the notion that the mistreatment by others might affect the victim's sense of self in a negative way, an element that may not exist in instances of betrayal towards an entire community.

The sense of betrayal seems to be related to the development of MC due to moral reasoning (Rachman 1994, Fairbrother and Rachman 2004, Rachman 2004, Fairbrother, Newth et al. 2005, Herba and Rachman 2007, Rachman 2010, Coughtrey, Shafran et al. 2012, Rachman, Radomsky et al. 2012). Not only are individuals shocked at acts of betrayal, but they also report feelings of being unfairly mistreated and in certain situations even violated (Finkel, Rusbult et al. 2002, Rachman 2010). Recently researchers have focussed on betrayal in general, and the extent to which individuals suffering with OCD and MC report feelings or experiences of betrayal. Pagdin and colleagues (under review) found betrayal scores are significantly higher in individuals with OCD compared to depression, anxiety, and an analogue sample (Pagdin, Salkovskis et al. In press). Further, the researchers found a positive correlation between betrayal and MC scores, consistent with the idea that feelings of betrayal are fundamental in the development of MC.

Incidences of betrayal can be associated with either physical or psychological violations if the perpetrator is a trusted person. These attacks may result in feelings of worthlessness, dirtiness and becoming tainted, causing the development of

neutralising behaviour (Rothbaum, Foa et al. 1992, Fairbrother and Rachman 2004, Rachman 2004, Fairbrother, Newth et al. 2005). Other instances can be more direct, in one case the patient had developed MC as a result of their partner being unfaithful (Finkel, Rusbult et al. 2002, Rachman 2010). In this example, the individual could no longer wear clothes that had been bought by the former partner for feelings of dirtiness (Rachman 2010). Other cases that have resulted in the development of MC include being betrayed by an authoritative figure such as a priest, sexual abuse, and lacking the expected support of a friend (Rachman 2010).

Much of the research into betrayal and MC has used the 'dirty kiss' paradigm described in Chapter 1 (Fairbrother, Newth et al. 2005, Rachman 2010, Coughtrey, Shafran et al. 2012). Although these experiments do have the weaknesses as outlined earlier, the paradigm has generated a great deal of our scientific knowledge in regards to MC. In terms of betrayal, the scenarios have been altered to exacerbate the betrayal elements in each synopsis (Rachman, Radomsky et al. 2012). Particularly, in experiments 3 and 4, betrayal was increased by adding components including; the victim was a friend's younger sister, the participant was trusted to take care of her, the participant publicly blamed the victim, and denial (Rachman, Radomsky et al. 2012). The researchers also included having each participant imagine their best friend complaining, using words such as 'trust and betrayed' (Rachman, Radomsky et al. 2012).

As hypothesised by the researchers, participants reported higher levels of anxiety, dirtiness, disgust and shame after they had imagined the scenarios in each experiment (Rachman, Radomsky et al. 2012). The study did not reveal many differences in the consensual kiss condition. The participants reported more intense negative emotions including guilt and sadness in the experiments where betrayal was intensified. Although the perpetrators did not indulge in any physical washing, such as the rinsing of the mouth in the dirty kiss, participants in the non-consensual experiments did report urges to wash (Fairbrother, Newth et al. 2005, Rachman, Radomsky et al. 2012). This study suggests that both the victim and the perpetrator can develop feelings of MC as a result of immoral behaviour, containing betrayal (Rachman, Radomsky et al. 2012).

The reason why the perpetrator may develop feelings of MC after performing an act of betrayal may be due to the idea of behaving morally and internalising the negative thoughts that may be a consequence to such negative behaviours. In bullying for example (see chapter 2), the bully may behave aggressively to gain respect and an increase in status within the peer group (Baldry and Farrington 2000, Baldry 2004). However, the literature suggests that some bullies may actually feel guilty and disgusted with themselves after inflicting harm on others (De Wet 2005, Evans, Ehlers et al. 2007, Rachman, Radomsky et al. 2012). It is plausible to suggest that betrayers may be shocked by their behaviour and may begin reasoning that they are nasty people for being so hurtful, which may result in the reappraising of their self-perceptions. Similar to the victims, the perpetrator

may internalise the idea that they are a nasty person and begin attempting to wash the feelings of disgust and dirtiness away.

Degradation

Although the perpetrator of negative actions may develop feelings of MC, degradation is another concept to be associated with MC, and is often experienced by the victim of such traumatic events. After rape for example, the victim can feel degraded, whereas the rapist most likely would not (Tyler, Hoyt et al. 2001, Negrao, Bonanno et al. 2005). The Oxford dictionary defines degradation as "to treat or regard (someone) with contempt or disrespect" (Oxford Dictionary, 2013). This definition is similar to that of humiliation. It is worth distinguishing between the two feelings or experiences in greater detail, particularly as it pertains to the concepts being discussed in this thesis. Humiliation is similar in that it is an intentional negative action by another person that leads to the individual feeling embarrassed, usually in a public environment. The researcher believes that degradation on the other hand, consists of a more aggressive psychological act, almost as if the perpetrator is attacking the victim's sense of self, rather than simply embarrassing them. Degradation may cause the individual to internalise the negative event and begin questioning their competency or worth in society, and even their social rank (Gilbert 1997).

An incident of degradation that is internalised can cause the victim to re-evaluate his or her own self-perceptions. The original self-beliefs pertaining to one's characteristics, such as intelligence, attractiveness, skills, may become reassessed as a consequence of the degrading incident (Gilbert 1997, Gilbert 2000). The researcher believes if an individual's self-perception is altered as a result of degradation, the person almost certainly feels more negative about their self, and may also experience a reduction in self-esteem. A consequence of re-evaluating one's own characteristics can be a decline in social rank (Gilbert 1997). This can be coupled with feelings of inferiority, low self-esteem and the perception that other individuals look down on the self (Gilbert 1997, Gilbert 2000, Gilbert, Allan et al. 2002). It may be worth highlighting here the fact that misevaluations are often associated with OCD and an inflated sense of responsibility (Salkovskis 1985, Rachman, Thordarson et al. 1995, Salkovskis 1999, Salkovskis, Shafran et al. 1999). A similar mechanism may be operating in incidents of degradation and the way in which victims evaluate their self. These negative evaluations may result in biased negative cognitions towards the self, resulting in feelings of worthlessness and possibly MC.

Gilbert has related self-perception with the notion of social rank (Gilbert 1997, Gilbert 2000, Gilbert, Allan et al. 2002). In social situations the goal of many individuals is to be accepted by their peers. This may occur as early as school-aged children attempting to make friends, or as late as professionals networking throughout their career. Gilbert argues that one reason why individuals desire acceptance in social environments is to improve their status (Gilbert 1997, Gilbert 2000, Gilbert, Allan et al. 2002). In order to increase one's social rank, an

individual requires valuable attributes or characteristics that may demand acceptance in social situations.

Self-esteem is a characteristic often associated with popularity and high social rank (Rosenberg and Pearlin 1978, Gilbert 1997, Gilbert 2000, Gilbert, Allan et al. 2002, Sassaroli and Ruggiero 2005). An individual may accentuate their ability in sport for example to gain acceptance of others and develop feelings of value and worthiness within their social environment. Degradation can have a dramatic affect on an individual's social rank by attacking a person's sense of self and denying the opportunity of acceptance. This is especially the case when the perpetrator of such attacks is of a higher social rank than the victim, and has already gained a degree of acceptance. An individual's social rank can be reduced as a consequence of being degraded in a public situation. The desired feeling of value and worthiness may be replaced with disrespect and worthlessness, feelings that may be associated with MC.

In some situations degradation can even result in the victim feeling tainted, a concept introduced in Chapter 1, that seems a common feature of MC (Rachman 2004, Coughtrey, Shafran et al. 2012). The notion of being tainted seems to take the theory of MC back to the pollution of the mind (Rachman 1994) ideas, with a very internal feel. The Oxford dictionary defines taint as; "to damage or spoil the quality of something or the opinion that people have of somebody/something" (Oxford Dictionary, 2013). The word 'spoil' has connotations of contaminate, and the definition suggests that it may affect self-perceptions. In terms of synonyms, the dictionary associates taint with nouns such as stain, blemish, tarnish, fault, defect, and verbs; pollute, contaminate and infect, which seem to reflect the cognitive nature of MC (Oxford Dictionary, 2013). These words also support the notion that feelings of internal dirtiness cannot be cleansed through washing, a traumatic incident, possibly being betrayed or degraded, has potential to become ingrained into the individual's sense of self.

Degradation can be intensified if coupled with a sense of betrayal. If the perpetrator is someone that the victim has a trusted bond with, the feeling of degradation can be exacerbated. The victim may not expect such negative behaviour from a trusted person, so the feeling of being degraded is much worse. Similarly, the feeling of being tainted can be exacerbated when the sense of betrayal is also experienced. If the perpetrator is a long-term friend or family member for example, the feeling of being tainted may be more intense because of the great deal of time spent with that person. This may be related to the notion of self-contamination, in that the victim may take responsibility for not discovering the negative attributes of the perpetrator earlier, which may also be associated with feelings of self-blame. This may trigger the same worthless and dirty feeling as with degradation alone, and compulsive washing or other neutralising behaviours may be a consequence.

Mental Defeat

Along with the idea of a reduction in social rank, researchers have also explored

the reduction of a sense of agency; the feeling of having a sense of self, being in control, and having a sense of worth in society (Libet, Gleason et al. 1983, De Vignemont and Fourneret 2004, Tsakiris, Sch tz-Bosbach et al. 2007, Engbert, Wohlschläger et al. 2008, Longo, Schr et al. 2008). As mentioned above, in certain situations individuals can have a demotion in social rank as a result of a traumatic event, such as bullying for example. Similarly, an individual can feel 'defeated' as a result of similar traumatic events (Gilbert, Allan et al. 2002, Tang, Salkovskis et al. 2007). Gilbert labelled this feeling as 'mental defeat', which is highly related to depression (Gilbert 2000, Gilbert, Allan et al. 2002).

The theory is that in certain situations an individual can feel so demoralised that they lose the motivation to try and escape the situation, become helpless, and therefore mentally defeated (Gilbert and Allan 1998, Gilbert, Allan et al. 2002, Gilbert, Gilbert et al. 2004). For example, in incidences of rape, the victim is often degraded, humiliated, and physically made to feel worthless (Brewin, Andrews et al. 2000, Ehlers, Maercker et al. 2000, Gilbert, Gilbert et al. 2004). Some victims will continue to fight and mentally plan escape routes and strategies to survive the ordeal, which is the opposite of mental defeat (Dunmore, Clark et al. 1997, Dunmore, Clark et al. 1999, Ehlers, Maercker et al. 2000).

Defeated individuals often feel helpless and that there is no point trying to escape because any effort would be futile. Mental defeat occurs when the individual actually loses the sense of agency (Tsakiris, Sch tz-Bosbach et al. 2007, Taylor, Gooding et al. 2011, Whitley 2011). This is defined as being perceived as seeing oneself as no longer being a human with any rights, they have become almost an accessory to the perpetrator and have no right to try and escape; allowing the attack to continue. The individual may feel that they even deserve the attacks, which returns to the idea of responsibility.

Gilbert claims that there are three main causes of mental defeat: 1) failure to attain or loss of valued resources; 2) social put-downs or attacks; 3) internal attacks, self-criticism, unachievable ambitions and unfavourable comparisons (Gilbert and Allan 1998, Gilbert, Allan et al. 2002, Gilbert, Gilbert et al. 2004). Mental defeat seems to be highly related to degradation. The first two causes have fundamental feelings of degradation. The second trigger for example may be considered pure degradation. It may be argued that the reduction or complete loss of agency may be a consequence of attacks to the victims' sense of self, leading to subsequent feelings of worthlessness.

The fact that mental defeat can lead individuals to feel worthless and 'deserving' of negative behaviours, it may be plausible to draw relationships between mental defeat and feelings of MC. Mental defeat in general would not produce compulsive washing in individuals because, as explained above, these individuals give up and would see no point in attempting to alleviate their distress by performing neutralising behaviours. However, the researcher suggests a concept of conditioned mental defeat. The idea is that after such a traumatic event the victims

feel so dirty that they must compulsively wash to avoid further punishment. These individuals may feel responsible for contaminating others and compulsive washing may neutralise such concerns. If the individual is unable to perform such neutralising behaviours, they may develop mental defeat.

Conclusion

Every sub-component of this chapter, self-perception, betrayal, degradation, and mental defeat, can all be related and may all be experienced in negatively toned interpersonal situations. For example, an individual may be degraded by a person whom they trusted, producing a sense of betrayal. As a result, the individual may experience a reduction in social rank, resulting in mental defeat. If for example an individual is raped by a "friend", all four feelings may be experienced. This is not to suggest that an individual has to experience all the concepts outlined above to develop feelings of internal dirtiness. Research is required to understand how these concepts affect MC, and how they interact with each other.

The type of traumatic experience will also dictate which of these concepts are felt by the individual. Victims of physical bullying may not report feelings of betrayal as much as victims of psychological bullying, for example. The author suggests the more intimate the incident, the more likely it is that individuals will experience more of these concepts, and potentially develop MC.

To investigate whether victims of bullying develop forms of contamination fears, the author aims to create a series of studies. The first of which will be designed to explore whether or not individuals from the general population are more likely to report feelings of dirtiness if they have experienced bullying. Study 1 is outlined in the next chapter and the findings will be discussed.

Chapter 4 - Study 1: The Relationship Between Experiences of Bullying & Mental Health

Introduction

In chapter 2 the experience of K was discussed. K had personal experience of bullying during childhood and later developed obsessive and compulsive symptoms which she clearly related to the bullying. From descriptions of lived experience such as that of K and from the work of Rachman and his colleagues, the idea of investigating the relationship between experiences of bullying and Obsessive-Compulsive Disorder (OCD) was developed, particularly in terms of triggers that may cause OCD and experiences of Mental Contamination (MC). As mentioned in previous chapters, MC almost certainly has a moral component (Rachman 1994, Rachman 2004, Fairbrother, Newth et al. 2005, Rachman 2006, Herba and Rachman 2007, Rachman, Radomsky et al. 2012). Patients who experience high levels of MC often report feelings of violation or being treated unfairly (Fairbrother and Rachman 2004, Rachman 2006, Herba and Rachman 2007, Rachman, Radomsky et al. 2012). There is also evidence to suggest that rape is a frequent trigger in the development of MC (Fairbrother and Rachman 2004, Rachman 2006, Coughtrey, Shafran et al. 2011, Coughtrey, Shafran et al. 2012). Rape victims often feel violated and are shocked that anybody could perform such an indecent and degrading act on another human being (Rothbaum, Foa et al. 1992, Fairbrother and Rachman 2004). Equally, feelings of betrayal, degradation and being tainted are also all experiences associated with fears of MC; all are often involved in experiences of rape (Freyd 1994, Koehler and Gershoff 2003, Fairbrother and Rachman 2004, Rachman 2010).

Bullying is another traumatic and degrading experience commonly endured during childhood (Olweus 1996, Kaltiala-Heino, Rimpelä et al. 2000, Fekkes, Pijpers et al. 2004). Similar to sexual assault experiences, the victims often report feeling betrayed, humiliated and violated (Kaltiala-Heino, Rimpelä et al. 1999, Fekkes, Pijpers et al. 2004). All types of bullying can be seen as 'immoral behaviour' as by definition it involves an abuse of power with the purpose of maliciously harming and distressing someone. Some children seem shocked that peers can be so hurtful in the playground, these students may be the victims of bullying or even bystanders that simply cannot believe some of the behaviour at school (Einarsen 2000, Glasø, Matthiesen et al. 2007). This can be coupled with feelings of degradation or humiliation if bullied in a public environment such as the playground, in front of friends and other peer groups (Crick and Nelson 2002, Fekkes, Pijpers et al. 2004, Janssen, Craig et al. 2004, Massari 2011, Sylvester 2011). These children may begin to withdraw and therefore reduce their time spent in social areas of the school. Some students even eat their lunch alone in a private location.

All forms of bullying can cause feelings of betrayal (Craig 1998, Townsend 2012), although the links and processes involved are poorly understood. Simply enduring immoral behaviour by a peer may trigger feelings of betrayal, as the child feels the

bully should be of equal status and should not be performing such hurtful behaviours. Feelings of betrayal can also be triggered or intensified depending on the role of trusted characters during these attacks (Hodges, Malone et al. 1997, Crick and Nelson 2002, Koehler and Gershoff 2003). If the bully is a friend, or if friends begin to participate in the bullying, instead of showing support, the victim can experience extremely intense feelings of betrayal. Humans trust their friends and have certain expectations of how these individuals should behave in different situations (Koehler and Gershoff 2003, Rachman 2010). If these individuals are inflicting pain, whether it be physical or psychological, bonds are broken, and the victim may feel violated as well as betrayed. The parents can also provoke feelings of betrayal and possibly violation, depending on their involvement in the bullying (Veenstra, Lindenberg et al. 2005, Sachs-Ericsson, Verona et al. 2006). For example, if they do not provide adequate support for the child, or seem in agreement with the bully.

To date, there have been no studies comparing those with a history of bullying and those without in terms of obsessive and compulsive behaviours. As the starting point for the present research, the researcher recruited (as samples of convenience) adults, some who self-reported having been bullied and some who did not. From the theoretical perspective described in chapter 2, bullying is conceptualised as a historical adverse life event.

Hypotheses & Research Questions

- T*he researcher expects participants who have experienced bullying to score significantly higher on the VOCI-MC and the washing subscale of the OCI, and for that effect to be over and above the effects of anxiety and depression.*
- The author predicts individuals who report being bullied by friends, having unsupportive parents, or having parents who seemingly agree with the bully, will have higher scores on the VOCI-MC.
- Participants who have experienced bullying will score higher in anxiety (GAD7).
- Individuals will score higher in depression (PHQ9) if they have been bullied.

Methods

Ethics

The University of Bath Psychology Ethics Committee granted ethics on 18/03/2013, ethics number 13-006.

Participants

A sample of 93 participants were recruited via advertisements on social media. 19 of the participants were male and 74 were female, and the age range of the sample was 16-70 years. Of the 93 participants, 39 reported experiences of bullying.

Every individual who contacted the researcher enquiring about the research were willing to take part in the study voluntarily. All participants opted to take part after reading through the information sheet (see appendix 24). After agreeing to take part each participant was asked whether they had experienced any bullying at school, and then they received the appropriate study pack – those individuals who did not experience bullying required a slightly shorter pack as the Bullying Experiences Questionnaire was irrelevant.

Materials and Measures

The current experiment used a set of seven questionnaires (see appendix, 1-9).

(i) *The Bullying Experiences questionnaire*: was developed by the current researchers for this study. It was largely based on the research and questionnaire produced by Olweus (Olweus 1996, Solberg and Olweus 2003). However, the author produced this scale so he could ensure the language was both friendly and accessible, easy to complete, and items were more relevant to the current research questions. It contained 68 items with a combination of tick boxes, Likert scales, and boxes for written answers. This combination was used to collect as rich and detailed information as possible. The survey revolved around the experiences of bullying during school, the different types of bullying that an individual may have encountered, the frequency of the attacks and questions relating to how the experiences affected their lives at school and during adulthood.

In terms of psychometric properties, the questionnaire is descriptive rather than a continuous scale, psychometric information such as internal consistency would not be appropriate. The fact that items were completed by a variable subset of participants made any detailed psychometric analysis impossible.

(ii) *The Obsessive-Compulsive Inventory (OCI, Foa, Kozak, Salkovskis, Coles, & Amir, 1998)*: has been incorporated to measure for OCD, and is widely regarded as the most effective at measuring obsessive-compulsive symptoms in general. There has been a revised version, the OCI-r (Foa, Huppert et al. 2002) but it is much shorter and therefore may miss valuable data. Of importance, the OCI yielded a test-retest reliability score of at least .68 (r = .68), with the majority of the subscales exceeding .80 (r = .80). Internal consistency also scored highly with a range of .86 - .95 (Foa, Huppert et al. 2002).

(iii) *Contamination Sensitivity Scale (Radomsky, Rachman et al. 2014):* This scale was designed to investigate the degree to which individuals feel distressed by the idea of being contaminated. The scale has high internal consistency (a = .91) and successful discriminant validity in that it can distinguish between individuals with contamination fears and others with OCD (non-contamination), anxiety and controls.

(iv) *Vancouver Obsessive-Compulsive Inventory-mental contamination (Thordarson, Radomsky et al. 2004):* the original VOCI has been frequently employed in other investigations surrounding OCD due to its high internal consistency (α = .96). Furthermore the scale also contains high convergent and divergent validities (Radomsky, Ouimet et al. 2006). It is important to note here that the mental contamination element of the VOCI has not been validated in terms of validity and reliability, as it is a recent edition that has not been used. The VOCI-MC is a much shorter questionnaire, only consisting of 20 items, because it focuses on mental contamination. Items include; "often I look clean but feel dirty", "I often feel dirty under my skin", "if I experience certain unwanted repugnant thoughts, I need to wash myself", so the questions are relevant to the current study.

(v) *Thought Action-Fusion Scale – mental contamination (Radomsky, Rachman et al. 2014):* which is specifically related to contamination has also been included to investigate whether thoughts of dirty objects or situations can result in the individual believing that they are now contaminated. This questionnaire has high internal consistency (α = .95).

(vi) *The Patient Health Questionnaire-9 (PHQ-9, (Kroenke and Spitzer 2002):* this is a brief scale to explore and measure depression in patients or participants in research. It is frequently used in the literature, has high internal reliability of .89 (α =0.89), and also has excellent test-retest reliability.

(vii) *Generalised Anxiety Disorder-7 (GAD-7, (Spitzer, Kroenke et al. 2006):* this scale aims to explore anxiety in general, and the findings are often related to GAD. The scale scored .83 (r=.83) in terms of test-retest reliability and has high convergent validity. Six of the seven items on the scale also score highly in divergent validity.

Procedure

The study began by recruiting participants through charities which support victims of bullying and via social media. The charities were contacted via email, and details of the study were either distributed to members or posted on the charities' website. This ensured that potential participants had the opportunity to read an invitation and an information sheet which explained what they can expect from the study, what was expected of them, and the aims of the experiment. Once they had agreed to take part, each individual was asked for a post address, and if they had experienced bullying at school. If the answer was yes, the experimenter would post all 7 questionnaires to be completed. If the participant answered no, a slightly reduced pack of 6 questionnaires was sent out as the Experiences of Bullying Questionnaire was unnecessary – these individuals formed the experiments control group. Participants were reminded of the anonymous nature of the study, the fact

that they can withdraw their details and answers at any time and the email address and telephone number of the researcher if they needed to make contact with questions or further information.

There was no time limit given to participants to avoid any questionnaires being rushed and to ensure that participants were comfortable. The pack included a free post address for the University of Bath so that once the questionnaires had been completed, they could be returned free of charge. Finally, once the researcher's had received the completed questionnaires, a debrief sheet was then posted or emailed which explained the study in greater detail and contained the researchers contact details again in case participants felt the need to communicate any further questions or queries.

Data analytic strategy

An omnibus mixed model ANOVA was first carried out with the measures of obsessionality (OCI), with t-tests for mental contamination (VOCI-MC), general anxiety (GAD-7) and depression (PHQ-9). Bullied vs not bullied was the grouping (between subjects) factor.

As a very approximate way of quantifying betrayal as part of bullying, a total bullying betrayal score was calculated by totalling the related items. In all three types of bullying, physical; verbal; psychological; there was a question asking whether the participant had been bullied by a friend, the individual ticked a box if they had. A score of 1 was given for each tick. The Bullying Experiences Questionnaire also contains an item relating to parental reaction to the bullying. As this is highly associated with betrayal, the researchers included this within the total betrayal score. These are the potential answers with their scores:

Supportive & helpful = 0
Supportive & not helpful = 1
Not supportive = 2
Didn't take the participant seriously = 3
Critical of the participant = 4
Critical & seemed to agree with the bully = 5

The first answer, 'supportive & helpful' was allocated the score of '0' because it is almost certainly the favoured, and to some degree expected, parental reaction, which should not provoke any feelings of betrayal. On the other hand, 'critical & seemed to agree with the bully' was given the score '5' because this answer should trigger the most intense feeling of betrayal. It is possible for participants to tick multiple boxes, increasing their betrayal score.

Finally, the researchers also included the question regarding friend's reaction in the betrayal score. This question had 3 potential answers: 'supportive', a positive reaction which has the score '0'; 'nothing' which could cause some feeling of betrayal due to relationship expectations so the researchers allocated it the score of '1'; and the third answer could have been that the participants' friends reacted by

joining in and bullying the victim too. This would almost definitely cause intense feelings of betrayal, so it has the score '2'. These scores were then added together to create the total betrayal score for each participant. This was then simply correlated with VOCI MC scores using a Pearson product moment correlation.

Results

Participants

Although 95 participants volunteered to take part in the study, 2 individuals were excluded as they did not complete the majority of the study pack. A further 4 participants missed a single questionnaire each within their pack, but the other data were included, giving a final total of 93 participants.

The between group means and standard deviations are shown in table 1 below.

Table 1: Descriptive statistics for each scale, in relation to both the bullied and non-bullied groups.

Scale	Bullied	Number	Mean	Stnd deviation	Sig
OCI Washing	Yes	39	5.79	8.192	.000
	No	53	3.06	3.774	
OCI Checking	Yes	39	6.62	6.636	.030
	No	53	4.64	4.816	
OCI Doubting	Yes	39	3.33	3.467	.363
	No	53	2.30	3.017	
OCI Ordering	Yes	39	5.51	5.534	.001
	No	53	3.66	3.757	
OCI Obsessions	Yes	39	12.31	8.237	.000
	No	53	4.47	5.430	
OCI Neutralising	Yes	39	4.90	3.892	.000
	No	53	1.98	1.813	
OCI Hoarding	Yes	39	3.18	2.873	.032
	No	53	2.00	2.312	
VOCI-MC	Yes	39	15.44	20.109	.000
	No	54	3.65	5.953	
S-CTN	Yes	39	24.67	21.872	.178
	No	54	19.24	16.697	
CTN-TAF	Yes	39	5.50	7.377	.497
	No	54	4.50	6.581	
GAD7	Yes	39	10.56	5.725	.021
	No	54	7.53	6.408	
PHQ9	Yes	38	13.28	8.846	.000
	No	54	7.02	6.199	

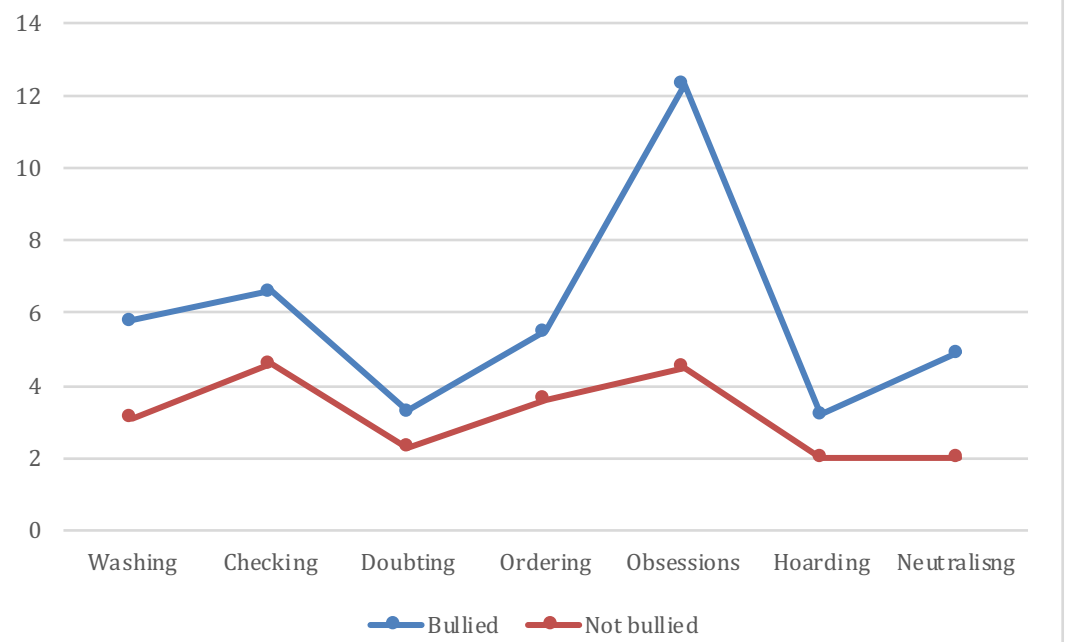
Table 1 illustrates the participant number, means and standard deviations for each questionnaire to compare the 2 groups.

In relation to the GAD7 (anxiety) and the PHQ-9 (depression), the t-tests found

significant between group differences on both $t_{(90)}$=2.389, p=0.019, and $t_{(91)}$=-3.799, p<0.0001 respectively, which suggests individuals who were bullied score significantly higher in both anxiety and depression compared to the control group.

In terms of obsessional symptoms (OCI) there were significant main effects of subscales washing, obsessions, hoarding and neutralising between the two groups; these were modified by a significant subscale by group interaction, shown in figure 1.

Figure 1
Means for each of the OCI subscales, for each group



Post hoc t-tests indicated there were significant differences for 4 of the OCI subscales: $t_{(90)}$=-2.146, p=0.035 for washing, $t_{(90)}$=-5.495, p<0.0001 for obsessions, $t_{(90)}$=-2.180, p=0.032 for hoarding, and $t_{(90)}$-4.799, p<0.0001 for neutralising.

In terms of Mental Contamination measured by the VOCI-MC scale, a t-test indicated significantly higher levels in those who had been bullied $t_{(91)}$=-4.075, p<0.0001.

T-tests were also performed to investigate whether the two groups scored differently in terms of the Sensitivity to Contamination scale, the t-test resulted in $t_{(91)}$=-1.357, p=0.178, not significant, and the thought-action-fusion questionnaire, $t_{(90)}$=-0.669, p=0.506, non-significant.

There was a possibility that the high MC scores are due to the high scores in anxiety and depression, rather than due to MC itself. A co-variance analysis was conducted to explore whether controlling for the impact of anxiety and depression removes the effect of bullying on MC scores or whether they remained significantly different. The main effect on MC of having been bullied remained significant after anxiety and depression were covaried. This suggests that the association between bullying and MC was not a non-specific effect of general distress associate with this unpleasant experience.

Figure 2
Adjusted means for each of the OCI subscales for each group, after co-variant analysis

A similar analysis was carried out with the OCI scales, with GAD-7 and PHQ-9 as covariates. The interaction and main effect of group remained significant; one way ANCOVAs for the individual subscales indicated that only the Obsessions and Neutralising subscales remained significant. Figure 2 shows the adjusted means for this interaction.

Experience of betrayal as part of bullying

The correlation between extent of betrayal as part of the experience of bullying and VOCI MC was small and non-significant $r_{[38]}$= -.076, ns.

Discussion

The results show clearly that being bullied is associated with the experience of more psychological problems, including mental contamination (MC), some types

of OCD symptoms, depression and anxiety. When the effects of anxiety and depression were controlled for in the analysis of MC and obsessional subscales, the effect remained for MC, obsessions and neutralising. However, when MC was controlled for, the effect of bullying did not remain for either anxiety or depression. These findings do suggest there is a link between the experiences of bullying, and the development of MC to some degree.

Hypotheses

The researchers had hypothesised that bullying would be associated with more psychological problems in general. The fact that participants in the bullied condition scored significantly higher in terms of anxiety, depression, and MC is consistent with this prediction. Participants who had experienced bullying did score significantly higher on the VOCI-MC, supporting another hypothesis and the premise that MC may indeed have a more specific relationship with bullying, in terms of developing the symptomology, or perhaps causing an individual to become more susceptible to MC. However, the study did not find a significant relationship with the washing subscale of the OCI, but this may reflect the lack of physical washing behaviours due to the cognitive nature of MC.

Finally, the study did not find any significant relationships between experiences of bullying, MC, betrayal and humiliation, so the third hypothesis was not supported. The betrayal and humiliation aspects were a secondary variable in this study and so the bullying questionnaire was not designed to explore these concepts directly.

Empirical Implications

In relation to OCD and MC, this was the first study to investigate their connection with experiences bullying, and there does seem to be a link which may be specific. Participants in the bullying condition scored significantly higher in the obsessions, hoarding and neutralising subscales of the OCI. Further research seems necessary to explore how bullying and OCD interact, based on these initial findings.

At this stage it is difficult to relate these early findings to any theoretical aspects of OCD. If the victims of bullying blamed themselves for the negative acts, it could be linked with the notion of an inflated sense of responsibility (Salkovskis 1985, Salkovskis, Shafran et al. 1999), but the current study did not explore this concept. Alternatively, victims of bullying often have to endure negative treatment on a regular basis (Fekkes, Pijpers et al. 2004), and could be connected with OCD through the obsessional nature of the disorder, but again, the study did not investigate this notion.

As mentioned above, this is the first study to explore the connection between experiences of bullying and MC, so there is not any other research to compare with. However, the study does provide evidence for several theoretical concepts developed in the field of MC. This study did not directly support the notion that betrayal can impact the development of MC (Rachman 2010, Warnock-Parkes, Salkovskis et al. 2012), although a considerable number of participants discuss related topics in the notes made on their bullying questionnaires. A key theme

mentioned by multiple participants is the negative role friends play in bullying, with quotes including: “my close circle of friends completely turned on me”; “Turning other friends against me”; “Several friends from primary school suddenly ‘turned’ and started hating and bullying me”. Some participants also discuss the ways in which their parents blamed them for the bullying: “My mother made me believe that I deserved everything bad”. These quotes could highlight feelings of betrayal, supporting Rachman’s theory (Rachman 2010).

Rachman discusses the role of ‘violation’ in the development of MC (Rachman 2004, Rachman 2006). He argues that violation can be experienced either physically and/or psychologically. Similarly, this study highlights the notion that bullying can be experienced physically, verbally and/or psychologically. The researcher argues that in some individuals, bullying can be seen as the violation discussed by Rachman, and may explain why participants in the bullied condition score significantly higher on the VOCI-MC.

Betrayal is believed to be highly related to MC (Rachman 2010, Warnock-Parkes, Salkovskis et al. 2012), and it is thought to be provoked in some traumatic experiences (Freyd 1994, Koehler and Gershoff 2003, Rachman 2010). However, the current study did not explore the concept directly, and although there were various questions subtly relating to betrayal, the non-significant correlation may be due to the lack of more direct questioning.

Participants in this study who reported experiences of bullying scored significantly higher on the anxiety questionnaire compared to those who did not experience bullying. The study is therefore consistent with the consensus that bullying does indeed cause anxiety (McCabe, Antony et al. 2003, Baldry 2004, Blood and Blood 2004, Camodeca and Goossens 2005, Carter and Spencer 2006, Swearer, Turner et al. 2008). Similarly, participants in this study who had experienced bullying scored significantly higher in depression compared to those who had no such experiences. This is consistent with the second consensus the bullying causes depressive behaviours (Craig 1998, Kaltiala-Heino, Rimpelä et al. 1999, Kaltiala-Heino, Rimpelä et al. 2000, Fekkes, Pijpers et al. 2004, Griffiths, Wolke et al. 2006, Frisen, Jonsson et al. 2007, Veenstra, Lindenberg et al. 2010).

Anxiety, depression, and now obsessive behaviours are not the only psychological problems associated with bullying. The researcher found participants reported eating, sexual and personality disorders, body dysmorphic disorder and phobias that could all be associated with their experiences of bullying. This was beyond the scope of the current study, but the fact that participants mentioned their disorders within the bullying could be consistent with those researchers who claim bullying can cause several different psychological problems (Craig 1998, Sweeting and West 2001, Blood and Blood 2004, Janssen, Craig et al. 2004, Swearer, Turner et al. 2008, Wolke and Sapouna 2008).

The fact that so many different psychological problems reinforces the need for

more preventative strategies to be implemented in an attempt to remove bullying from schools. Unfortunately this study was not designed to explore or support the more general research into the experiences of bullying.

Limitations

The sample is the major weakness of the current study. The researcher recruited 93 participants over three years. Reasons for the slow recruitment process are unknown and could be because of the sensitive nature of the study; each participant who reported experiences of bullying were asked to complete a questionnaire on the experience of it. It is possible that these questions and having to recall the painful experiences caused individuals to withdraw from the study without completing or returning the packs of questionnaires. Also, participants had the freedom to answer the questions at home, without any time constraints or any incentive for completing the questionnaires. It is possible that individuals lost the packs, or forgot about the study altogether.

As a result of the slow recruiting process and the lack of numbers, the researchers did not have the opportunity to use the planned experimental design in this study. Participants were recruited on an opportunistic basis, so the two conditions are not equal in terms of number, age, and gender. The small sample size negatively affected the data analysis too. The researchers were unable to conduct more specific analysis as participant numbers would have been too small to generate any meaningful conclusions.

That being said, it is important to remember that this is the first study to investigate the link between bullying and OCD & MC. The primary purpose was to see whether individuals who experienced bullying would show thoughts or behaviours associated with MC. The sample clearly indicate that participants in the bullied condition scored significantly higher on the VOCI-MC, suggesting there is a link between bullying and MC, providing evidence for hypotheses, and support for other studies in the field.

The researchers based this exploration on several questionnaires (see appendix 1-9), some of which had not been validated at the time on this study. In terms of MC, the VOCI-MC, Contamination Sensitivity Scale and the Contamination Thought-Action-Fusion have all been validated, and the associated research seems positive (Radomsky, Rachman et al. 2014). The Bullying Experiences Questionnaire remains unvalidated because it was designed for this study, and all the items included were associated with the aims and hypotheses of this study.

Betrayal, humiliation, degradation, disgust and the notion of being violated to some extent are all key concepts in the theory of MC. Although these ideas were subtly explored within the Bullying Experiences Questionnaire, in hindsight, the researcher could have included more direct items to explore the concepts further. This may have improved the study to a degree, but the theoretical ideas were not the primary focus of the study.

Finally, the researcher may have generated richer data if qualitative interviews were incorporated in to the study design. This technique may have provided more detailed information about the participants' experiences of bullying, parental reactions, and the concepts mentioned above. However, this would have taken much more time in terms of conducting the research, as well as transcribing and analysing the data. Recruitment was a difficult process, and incorporating interviews to the study may have made the process worse.

Conclusion

The current study was a preliminary exploration to investigate whether there was a possible link between experiences of bullying and psychological problems, in particular, mental contamination. The researcher suggested that individuals who had been bullied could feel degraded, humiliated, betrayed and violated to some degree, all of which have been associated with MC. Further, morality is believed to play a significant role in MC and bullying is certainly an immoral behaviour.

The researcher hypothesised that participants in the bullied condition would score higher in psychological problems. The study found that these individuals score significantly higher in anxiety, depression, some aspects of OCD, and MC. The study is consistent with the researcher's hypotheses, and provides evidence for research in the field of bullying.

MC is a relatively new concept, and this study can be considered a positive initial investigation. By highlighting a connection between MC and bullying, researchers in the field can improve the theory, and potential triggers. Researchers also need to explore this link in more detail and try to identify what areas of bullying in particular are associated with MC.

In the next chapter, the researcher explores therapist's attitudes towards bullying, and whether they believe it affects the development of psychological problems. This study highlights a link, so it is important for therapists to consider this when treating patients. The researcher explores this link in a clinical sample in following chapters. It is important to understand if the same link can be found in individuals diagnosed with obsessive-compulsive disorder, and whether there are any differences.

Chapter 5: Study 2 – An investigation to explore the attitudes of therapists towards bullying and their effect on mental health problems.

Introduction

The first study in this programme was an initial investigation to explore a potential link between experiences of bullying and the development of mental contamination (MC) in a general population sample. The researcher found that participants who have experienced bullying score significantly higher on the VOCI-MC, GAD7, PHQ-9, OCI washing subscale, OCI obsessions and OCI neutralising subscale. These findings clearly suggest a relationship between bullying, OCD, MC, anxiety and depression. As mentioned in previous chapters, the researcher hypothesises that bullying may influence the development of MC in at least two ways: experiencing bullying, betrayal and the other feelings that are associated with this type of victimisation could cause a child or young person to become more vulnerable to developing MC fears related to later betrayal events, and potentially OCD later in life; or experiences of bullying may, in some cases, directly trigger feelings of internal dirtiness immediately. Regarding the first suggestion, if a child has experienced bullying and does develop a susceptibility to mental contamination (this may include a heightened disgust sensitivity, becoming more affected by, and then internalising, social put-downs or criticisms), there is a possibility that the individual could later develop MC or similar behaviours. The researcher believes that if a vulnerability is formed due to bullying, contamination fears may develop if the individual endures another traumatic event. Research and case studies highlight examples where incidents such as divorce and infidelity can trigger MC (Rachman 2004, Rachman 2006, Rachman 2010). For more information on the triggers and precursors hypothesised to be involved in the development of MC, see Chapter 3.

Study 1 investigated the potential relationship between bullying and mental health problems from perspectives of the victims. The sample was based on the general population, who were simply divided into those participants who had experienced bullying, and those who had not. Study 2 aims to explore the same topic, but from the perspective of therapists. The key question that the researcher hopes to answer is "do therapists believe that bullying is influential in the development of mental health problems?". The importance of this question relates not only to the extent to which therapists as a group have identified bullying as a possible significant factor in mental health problems but also the extent to which bullying may therefore form part of the assessment and formulation (and therefore treatment) of these therapists.

In Chapter 2, the researcher considered the empirical evidence which has been published connecting bullying to the development of mental health disorders. Investigations suggest that bullying is strongly associated with anxiety and

depression (Berguno, Leroux et al. 2004, Athanasiades and Deliyanni,ÄêKouimtzis 2010), but more specifically bullying has been associated with other disorders, including BDD, GAD, eating disorders (Kaltiala-Heino, Rimpelä et al. 1999, Berguno, Leroux et al. 2004, Blood and Blood 2004, Veale 2004), amongst others. However, at present there are no published articles connecting bullying experiences with OCD or MC.

Hypotheses & Research Questions

This is very much an explorative study so there are no hypotheses to test. There are more research questions, such as "Which psychological disorders are most associated to bulling according to therapists?". This could be associated with the frequency to which professionals read recent investigations published in journals. If therapists operate on a purely "evidence based" approach then it might be expected that those problems which research indicate a link would be identified. So, the author is interested in "Do therapists report the same disorders to be associated with bullying as the recent literature?". This would include disorders such as BDD, GAD, depression, social anxiety and eating disorders (Kaltiala-Heino, Rimpelä et al. 1999, Glover, Gough et al. 2000, Baldry 2004, Janssen, Craig et al. 2004, Camodeca and Goossens 2005, Wolke and Sapouna 2008, Veenstra, Lindenberg et al. 2010). It also seems unlikely that therapists will have no opinion, leaving the question "How their attitudes might have formed?". Those unfamiliar with the research are most likely to rely on their own experiences or an implicit "common sense" theory, which may of course simply reflect their cultural prejudices.

It is to be hoped that the accumulation of experience will tend to correct any misconceptions about such links. The study can explore the question "do the more experienced clinicians have more accurate perceptions of the links between bullying and mental health?".

The research highlighted above thus suggests that bullying can play a role in the development of mental health problems. The researcher has designed this current study to explore the degree to which therapists believe there may be a link between bullying and mental health problems including OCD. MC is a relatively new concept so the participants are not necessarily expected to draw a link between experiences of bullying and MC, or even mention fears of contamination at all.

Overall, the purpose of the study is primarily exploratory to identify the extent to which therapists consider bullying and mental health problems to be linked, to consider the extent and degree of perceived specificity by diagnosis and to evaluate the impact of experience of these factors.

Methods

Ethics

Ethical approval was obtained through the ethics committee at the University of Bath on 1/11/2013, ethics 13-127/13-046.

Participants:

A sample of 62 participants were recruited from continuing professional development workshops that were run by the researcher's supervisors for qualified staff; however, the majority were recruited through Twitter. 12 participants were male and 50 were female. All participants have had experience of treating patients with mental health difficulties; this ranged from 24 to 72 years of age. The only inclusion criteria was that participants must have had experience in treating individuals with mental health difficulties in a professional capacity.

Materials and Equipment:

Before any participant receives the study pack they have the opportunity to read the information sheet (see appendix 26). This is a document explaining the rational for the study, what is involved, and what is expected of the individual. The study pack consisted of a consent form (see appendix 10). A demographic sheet was used to collect information such as years of experience, age, gender etc. (see appendix 11). The first measure is in a simple quantitative survey format, identifying key diagnostic categories and asking participants to identify the frequency with which they have seen particular groups in the past 12 months. These were surveyed as class intervals rather than absolute numbers on the basis that participants were unlikely to remember absolute numbers of patients seen. Following their estimate, they were asked to identify the diagnostic categories which they considered to be most likely associated with bullying. (see appendix 11).

The study included the Attitudes Towards Bullying scale, which was designed by the author and supervisor specifically for this study on the basis of aspects of bullying reported in the literature. Other therapists in the host department were also consulted in the generation of these items (see appendix 12). It has text boxes for written answers, as the researcher believed this may yield information that quantitative questioning may have missed. Likert scales were included to ask questions relating to how often do their patients report bullying, discuss experiences of bullying, how common is bullying among individuals with mental health difficulties, etc., quantitatively (see appendix 12).

Finally, each participant receives a debrief sheet (see appendix 27). This document explains the study in greater detail, and includes contact information for both the researcher and supervisor for any questions or queries they may have at a later date.

Procedure

Participants were recruited from either professional development workshops or via

Twitter. Before each participant received the study pack, they had the opportunity to read an information sheet that described the study (see appendix 26). The form highlights what is involved in the study, why the researchers are carrying out such a study, and what is expected of each individual who participates. The form also reminds each person that they could withdraw their data from the study at any time simply by emailing the researcher. If the individual is happy, they are then asked to complete the consent form (see appendix 11). Once this has been completed, the participant is then given the questionnaires (see appendix 12). If the participants are recruited from a workshop, this process is done face-to-face, and the participant was given the option of completing the questions during the workshop (in scheduled breaks), or take the pack home to complete and return it via the free post address.

If the individuals are recruited via Twitter, the information sheet was distributed via email or blog post. Once they had opted to take part, the research pack was then posted to each individual, to an address specified by the individual. In most cases this is a home address, but work addresses were occasionally provided. The pack included the consent form and questionnaires.

Once the researcher received the completed questionnaire, the participants were then handed or emailed a de-brief sheet that contains more information about the study, as well as the contact details of the researcher (see appendix 27). At this stage, each participant had the opportunity to ask as many questions as they liked.

Data analytic strategy

The study employed mainly a qualitative approach to its data analysis. The quantitative analysis included descriptive statistics, and some exploration of potential correlations between therapists' beliefs about bullying and psychological disorders.

The qualitative analysis process was broadly guided by Braun and Clarke's (2006) thematic analysis (Braun and Clarke 2006). During this process, the author considered issues of reliability, validity, and rigour in relation to qualitative research. With this in mind, two other researchers were involved in the analytic process: Professor Paul Salkovskis, supervisor and clinical psychologist; and Doctor Rowena Pagdin, clinical psychologist. These researchers have prior knowledge of using thematic analysis as well as experience of working with people diagnosed with OCD. The analysis was conducted by three researchers with different points-of-views, reducing bias that could might result from using a single researcher approach. All three researchers developed similar themes during the analysis process, suggesting there was a degree of internal consistency between the three researchers (Tuckett 2005, Fereday and Muir-Cochrane 2006).

Quality of the analysis was further evaluated by Braun and Clarke's 15-point checklist (Braun and Clarke 2006). Throughout the analysis process, researchers followed the guidance described by Braun and Clarke (2006). The stages of analysis included researchers first familiarising themselves with the data. This

included collating all the qualitative data (responses from the participants) into a single Word document. This enabled the main researcher to read responses on a screen with an ease. All the responses were read several times in order for the researchers to familiarise themselves with the data.

The data was then coded, line-by-line. These codes remained closely to what the participant had said. The codes helped to summarise and abstract what the participants had said. These codes formed a basis for the further analysis stages.

The next stage involved grouping the codes together to develop the initial themes. It is important to note here that this was based on the meaning abstracted in the codes, rather than the actual words in the quotes. In other words, the themes were developed from the codes, rather than the quotes.

Initial themes were then reviewed. Drawing a thematic map helped in this process. In some instances, themes were extremely similar, so the researcher was able to merge the initial themes into one larger overarching theme. During the development of the themes, the researcher frequently examined the original data and the participants quotes to ensure the themes fit with the data.

The three researchers were involved in the process of developing the initial themes into final themes. They used Skype to discuss the coding, developing initial themes and theme maps. It was important to spend enough time on this process. Some themes were re-worded to incorporate the input from each of the three researchers. In general, however, the themes were very similar, and it was easy to agree and finalise these themes. Even though there was an agreement between the researchers, it is important to note that the themes reflected the therapists' thoughts, experiences and social context. This is a central part of the qualitative approach and should not be seen as a limitation of the research.

Finally, the researcher analysed each theme for clarity and consistency, and made sure the theme descriptions fitted with the meaning in the original data and participant quotes. When writing the report, the main researcher selected quotes for each theme. For validity and reliability reasons, it was important to select quotes from as many different participants as possible. The quotes were used to illustrate each theme.

Results

Participants

Of the sample of 62 participants, 12 were male and 50 were female. The youngest therapist was 24 years of age and the oldest was 72 years of age. In terms of years of practise, this ranged from new trainees to a therapist with 41 years of experience. The only criteria for the current study was that participants had experience of treating individuals with mental health difficulties. The researcher did not specify job role so the sample contains participants in a variety of positions

including nurses, counselors, psychiatrists, but most were CBT therapists.

The questionnaire item "which psychological disorders do you believe are affected by bullying" - Participants were presented with a list of 14 disorders and they had to tick which they believed would be affected by experiences of bullying. The table below illustrates the participants' answers:

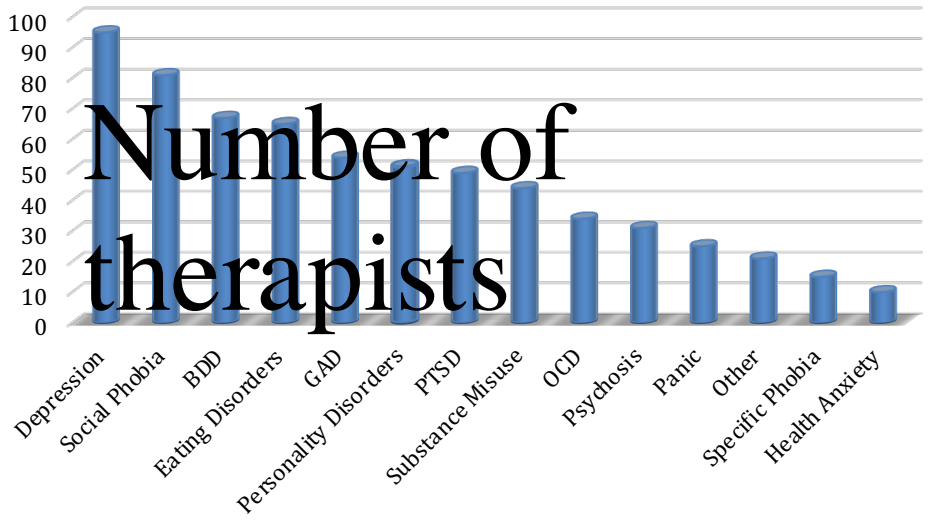
Table 2: List of psychological disorders and numbers of therapists who said yes/no to whether they're affected by bullying

Disorder	Affected by bullying	
	Yes	No
Body Dysmorphic Disorders	41	21
Depression	58	3
Eating Disorders	40	20
Generalised Anxiety Disorder	33	28
Health Anxiety	6	55
Obsessive-Compulsive Disorder	21	40
Panic	15	46
Personality Disorders	31	30
Post-Traumatic Stress Disorder	30	31
Psychosis	19	42
Social Phobia	50	11
Specific Phobia	9	52
Substance Misuse	27	34
Other	13	48

Please note: 1 participant did not answer these questions so the data is missing.

Figure 3 below shows all the therapists' answers in percentages.

Figure 3
Therapist's answers in percentages:
Which disorders are most affected by bullying?



OCD received a relatively low score of just 34%. This could have suggested that therapists did not generally believe bullying was linked with OCD, possibly because the participants did not have sufficient knowledge or experience of the disorder in general. To explore this account, the researchers analysed the question relating to how often these individuals treated individuals with OCD. Participants were divided into two groups; therapists who had treated people with OCD regularly in one group, and rarely in the second. This used the results of the question: "How many clients with each of the following disorders as their main problem have you treated in the last 12 months?". Participants who reported treating under 10 clients were allocated the 'low familiarity' group, and the remaining therapists who treated over 10 individuals with OCD were selected for the 'high familiarity' group. 26 participants were allocated to the low experience group and 35 to the high.

A chi-square test to investigate whether those therapists who were more familiar with OCD were more likely to link the disorder to bullying, compared to those individuals who were less familiar. The test found χ^2 (1) = 4.64, p <.05, significant. 81%, 21 of the 26 participants in the unfamiliar group did not believe OCD was related to bullying, compared to the familiar group where 54%, 19 from 35 individuals believed there was a connection.

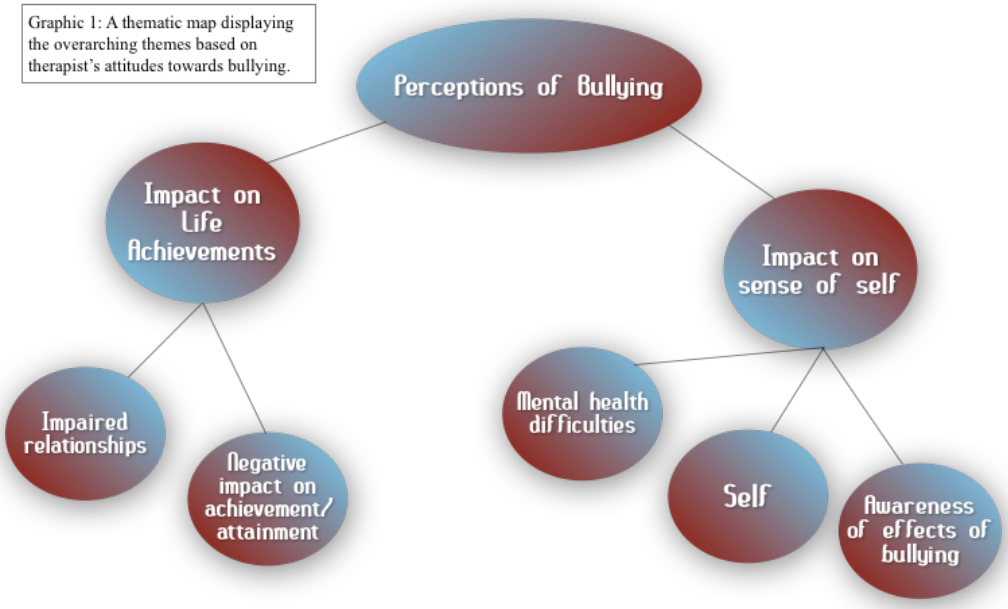
The final quantitative investigation was a correlation to explore pre-determined questions. Firstly, the researchers performed a correlation to investigate whether there was a relationship between therapists who ask about bullying and the frequency that patients reported experiences of bullying. The correlation was significant r=0.353, n=60, p=0.0006 as was the relationship between the frequency

that the therapist believed bullying occurred and how often they asked their patients about experiences of bullying (r=0.314, n=61, p=0.014).

Thematic analysis

Using Thematic Analysis (Braun and Clarke 2006), the researchers developed 2 overarching themes from the written answers. Graphic 1 illustrates these overarching themes, as well as the sub-themes.

Graphic 1: A thematic map displaying the overarching themes based on therapist's attitudes towards bullying.



Impact on life Achievements

In general, therapists spent a significant amount of their responses discussing how the experiences of bullying can impact on a child's life achievements. The analysts formed this overarching theme by combining 2 sub-themes; impaired relationships and negative impact on achievements and attainment.

Negative impact on achievement/attainment – The first sub-theme is directly linked to the overarching theme. Most of the therapists discussed how difficult it is for an individual to achieve their potential when they are experiencing bullying throughout school. When somebody considers bullying, it is common to associate it with childhoods, school experiences in particular. So, it is unsurprising that a great deal of the participants' comments related to school life.

P59: "Negative impact on education"
P26: "I think there has been a negative impact on educational engagement and achievement for those experiencing bullying"
P22: "Not achieving full potential as leaving school early/won't complete exams. Also not achieving what they are capable of!"

P61: "Non-attendance"

P14: "…it can reduce their ability to engage in classroom education and attendance"
P40: "…affect their ability to attend school"

P31: "…difficulty concentrating"
P33: "affects concentration"

These quotes reflect the broad manner in which bullying can affect the victim's education. Participants also mentioned concentration, distractions, revision, exams, perfectionism, attendance, and confidence are other aspects of a student's life that may be impacted by bullying.

Education is so important in an individual's life, not only because qualifications lead to employment, but also due to happiness, quality of life and contentment. If these are affected by a traumatic experience such as bullying, this could have a direct impact on the individual's mental health.

Impaired relationships - The second sub-theme is related to the life achievements overarching theme in terms of the individuals' ability to form relationships. A number of therapists in this sample commented that experiences of bullying can affect the victim's ability to develop relationships.

P6: "can impact their willingness to engage in relationships for fear of the cycle repeating"
P39: "harder creating new relationships with people"
P44: "…impact on relationship with others"

P60: "…issues around trust"
P43: "people may find it harder to trust others"
P7: "distrust of others"

P35: "often may enter an abusive relationship"

Most therapists simply commented that they believe bullying can negatively affect the ability to form relationships in general. However, a few participants suggested that some victims may seek out or find themselves in abusive relationships. Further, therapists' comments indicate that they believe this could be because the individuals expect or feel that they deserve the negative treatment. A few participants also mentioned that the victims could develop trust issues which could affect intimate relationships, friendships, relationships in the workplace and relationships with their therapist if the individual has to seek help.

Impact on sense of self

As mentioned in previous chapters, the author believed one of the mechanisms connecting MC to bullying revolved around the individuals send of self. Due to the considerable comments relating to the self, and the fact that therapist mention it

throughout the questionnaire, the analysts developed it as the second overarching theme. This construct has been developed from 2 sub-themes; mental health difficulties and self.

Mental health difficulties - The first sub-theme revolves around mental health difficulties, which is unsurprising given the topic of this study. The general consensus among therapists in this sample was that bullying can influence a persons' mental health difficulties, but there is a range of answers in terms of the extent that this form of trauma can impact the victim.

P1: "I think it is a strong relationship. A significant number of the people I have seen for counseling over 20+ years have experienced bullying. It can have a major impact on self-esteem and also lead to a sense of isolation"
P59: "I think there is possibly a strong relationship between being bullied and presenting with social anxiety/social phobia"

P48: "There is a relationship"

P47: "potential for bullying to predispose some people to mental health difficulties. Many people who are bullied however, do not go on to mental health problems"

P27: "I think bullying is not usually a cause of MH problems but definitely contributes to it"

The majority of therapists in the study seem to agree that bullying can have a significant impact on an individuals' mental health. The participants also made suggestions specifically on how they believe victims react to bullying.

P58: "Increase in anxiety especially in social situations"
P17: "often more socially anxious"

P55: "in childhood it can result – depression, anxiety etc"
P12: "may make them feel hopeless and depressed"

P42: "strengthens/develops core beliefs"
P2: "…particularly in forming negative core beliefs"
P23: "develop unhelpful coping styles such as avoidance"

The participants comments reflect most of the recent publications on bullying in that therapists reported anxiety and depression as the symptoms most associated with bullying. Eating disorders and other anxiety disorders such as BDD or GAD were hardly mentioned by this sample. Not only does this highlight the lack of knowledge in the field of bullying, it also suggests the more studies investigating more specific disorders need to be more accessible.

Self – This is the second, more specific sub-theme that was developed because so many therapists provided comments about distinct aspects of the individual's sense of self.

P11: "fear of negative judgements, poor self-esteem, vulnerable identity"
P28: "low self-esteem"

P15: "childhood bullying seems to create or reinforce negative beliefs particularly about the self"

P16: "low/poor self worth"

P29: "can confirm negative beliefs about self"

P53: "negative opinion, value/worth"

Most participants did making comments about a decrease in self-esteem, which is unsurprising given the trauma that victims of bullying have to endure. Low self-esteem coupled with feelings of worthlessness could potentially lead to the individual re-appraising their sense of self. As mentioned in previous chapters, the author believes that if an individual is questioning their sense of self, they may begin to believe that they are responsible for or deserve to be mistreated and accept the bully's comments as the truth. This can lead to anxiety, OCD and possibly MC (see chapter 3 for more information).

Awareness of effects of bullying - In this third sub-theme, the analysts found many therapists discussed whether or not victims associated their mental health difficulties with their bullying. This topic was mentioned throughout the questionnaire and therapists' had varying views.

P5: "not good awareness"
P10: "might not see the link"

P41: "some don't make a connection"

P37: "some victims of bullying may make a link between this and their mental health – others may need help to make this link"

P57: "some may play it down + dismiss impact but others understand it's part of it"

The attitudes range from being completely unaware that their psychological issues may stem from their experiences of bullying, to discounting the link, to blaming the bully; but this broad spectrum reflects the individual differences of the victims. The individuals may not have the ability to comprehend the relationship between

mental health difficulties and bullying, whereas others, such as K mentioned in previous chapters, have always contributed their current difficulties to the bullying experienced at school.

Discussion

This study was designed to explore the extent to which therapists believe there is a link between childhood bullying and the development of mental health difficulties. Research suggests that the experience of bullying can be so traumatic and distressing that, in some cases, the victims can develop psychological symptoms (Batsche and Knoff 1994, Olweus 1996, Craig 1998, Kumpulainen, Räsänen et al. 1998, Langevin, Bortnick et al. 1998, Kaltiala-Heino, Rimpelä et al. 2000, Camodeca and Goossens 2005, Veenstra, Lindenberg et al. 2005, Swearer, Turner et al. 2008, Wolke and Sapouna 2008). However, little is known about the attitudes of therapists in relation to this connection, or even how seriously they take the concept of bullying in the treatment setting. The fact that 95% of therapists believed depression was related to experiences of bullying suggests they support the notion that mental health difficulties can be related to bullying.

In terms of qualitative themes, the researcher developed three overarching themes in relation to therapists' attitudes towards the relationship between bullying and mental health difficulties. The first included impaired relationships' as well as 'negative impact on achievement/attainment. The latter contained statements where therapists discussed the relationship between bullying and mental health difficulties directly. The majority agreed with the author, suggesting there is a 'strong relationship', or acknowledging the idea that bullying has a 'significant impact on mental health problems'.

Another overarching theme develop was 'self', supporting another theory of this PhD program. The author believed an individual's sense of self is somewhat related to MC, and therapists in this discussed this topic, along with self-worth, self-perceptions, and self-esteem. Finally, the third overarching theme revolved around the degree to which had 'awareness of the effects of bullying'. This generated a broad range of answers. According to the therapists in this study, some clients are unable to connect their mental health difficulties to their experiences of bullying, whereas other participants suggested that some individuals can make the link but may need help to do so.

The general consensus among the sample seems to concur with the author: bullying can have a detrimental effect on a persons' mental health, and this should be considered when treating a new service user.

Hypotheses and research questions

The researchers identified depression, BDD, eating disorders, social phobia, and personality disorders would be most associated with bullying. This hypothesis is supported by 95% of participants suggesting depression can be affected by bullying, over 60% indicated that they believe social phobia, BDD and eating disorders were linked with experiences of bullying. The researcher was surprised

that only about half the participants suggested GAD and particularly PTSD were affected by bullying.

In terms of OCD, only a third of therapists reported that they believed the disorder is associated with bullying. Even when the researchers controlled for those participants who lack knowledge or experience in treating OCD, still only 54% of therapists identified the disorder as being connected with experiences of bullying. It is plausible to suggest that participants indicated OCD could be affected on the basis that it is an anxiety disorder. If individuals had a greater understanding of OCD and MC, maybe more therapists would have indicated that it is a disorder associated with bullying.

The current study sought to explore therapists' attitude towards mental health problems and bullying rather than producing direct evidence for the relationship between the two. However, the fact that the therapist's attitudes have been formulated by clinical experience, which would suggest that they have treated individuals suffering from psychological disorders, who also have had experiences of bullying. This is also consistent with the literature indicating an association between a range of psychological disorders and experiences of bullying (Craig 1998, Kumpulainen, Räsänen et al. 1998, Langevin, Bortnick et al. 1998, Kaltiala-Heino, Rimpelä et al. 2000, Camodeca and Goossens 2005, Veenstra, Lindenberg et al. 2005, Swearer, Turner et al. 2008, Wolke and Sapouna 2008).

Limitations

Although this study has produced some interesting findings in an area that needs considerably more research, there are of course limitations. Firstly, the investigation would have benefitted from a larger sample size. Greater numbers would have enabled fuller analysis, and more influence when extrapolating the findings and stronger conclusions. If the researcher had been able to recruit more therapists, the analysis may have been able to explore differences between job title; maybe clinical psychologists have different attitudes compared to psychiatrists or mental health nurses. The sampling also meant that, by definition, participants were most likely to have at least and interest in CBT relative to other therapeutic modalities.

When creating the questionnaire, the researcher could have added more detailed or specific items. The study did not explore views of therapists in relation to types of bullying, bullying intensity, or the attributes of the bully. Further, the researcher could have included items on the bully and what the consequences could be of spending school years being so nasty to others. Finally, the questionnaire could have contained some disorder-specific questions; do you think experiences of bullying can affect the development of GAD? If so, how? These types of questions may have yielded more detailed answers about each disorder of interest.

Conclusion

The study was designed to investigate the attitudes of therapists towards the

potential relationship between mental health difficulties and experiences of bullying. Although research indicates that some psychological disorders, namely eating disorders, GAD, BDD, as well anxious and depressive symptoms have been linked to bullying, little is known about the attitudes of therapists, and whether they even target it in the treatment setting.

The researcher expected participants to link bullying to anxiety, depression, eating disorders, and BDD as these are the psychological problems most associated with this traumatic experience. The study did find these disorders to be most linked to bullying by participants. Therapists did not really associate bullying with OCD, as predicted, and this may be due to MC being a relatively new concept and participants are just not familiar with it. As MC becomes more widely understood, maybe therapists will then make the link.

To build on the knowledge of Mental Contamination and to attempt to progress the theory, the researcher will explore the relationship between MC and bullying with the third study of the PhD. This investigation will be based on a sample of individuals who have been diagnosed with OCD, and a healthy control group.

Chapter 6: Study 3 - An investigation into potential factors that may influence experiences of OCD

Introduction

In the preceding two studies the potential relationship between bullying and mental health problems were investigated from two different points of view. The first explored relationships from the perspective of those individuals from the general population who had experienced bullying during school years compared to those who hadn't had such experiences. Study 2 investigated the suggested relationship with mental health problems from the point of view of therapists' attitudes and opinions to identify whether or not individuals who are experienced in treating patients with different mental health issues believe that bullying may affect or influence the development and treatment of such problems.

The present study approaches the subject from a further point-of-view building on the evidence from study one of there being a relatively specific relationship between the experience of having been bullied and mental health problems. The logic of the study is in relation to the first investigation which basically focussed on the question "do individuals who have experienced bullying score higher on various scales, including contamination questionnaires?" and which found a surprising degree of specificity in terms of the relationship between bullying and both OCD and Mental Contamination. Study 3 in effect turns this question around and focusses on "do individuals suffering with OCD and MC have extensive experiences of bullying?". To be more precise "do individuals suffering with MC report experiences of bullying to a greater degree when compared to individuals who suffer with OCD alone and a healthy benchmark?".

Study 3 was intended to examine the intensity of bullying, from no bullying to extreme bullying with a view to relating this to the intensity of contamination fears. However, it is extremely difficult to quantify the intensity or the severity of bullying. This is partly due to issues with the accuracy of self-report, the accuracy of an individual's memories (considering some participants can be in their sixties, recalling experiences that they suffered with over fifty years ago), and partly because the intensity or severity is by definition, subjective. As a result, the research focusses on types of bullying, the frequency, the duration, whether or not the individual had felt betrayed or degraded. The latter two factors have been implicated in the development of MC in prior research (Rachman 2010, Warnock-Parkes, Salkovskis et al. 2012, Coughtrey, Shafran et al. 2014). See chapter 3 for an introduction and explanation of the concepts associated with MC thus far.

Hypotheses & Research Questions

The aim of this study was thus to compare on the basis of descriptive and process-based questionnaires, people who have and have not been diagnosed with OCD and who had been bullied (or not).

Below are the researcher's hypotheses that will be tested.

- The researcher expects participants who have experienced bullying to score significantly higher on the VOCI-MC and the washing subscale of the OCI, and for that effect to be over and above the effects of anxiety and depression.
- In terms of betrayal, the author predicts individuals who score high on the VOCI-MC will report being bullied by friends, having unsupportive parents, or having parents who seemingly agree with the bully.
- These individuals will also score high on the betrayal questionnaire.
- Individuals who have being bullied and scored high in terms of the VOCI-MC will score high in terms of social put-downs.
- Participants who have experienced bullying will score higher in anxiety (GAD7).
- Individuals will score higher in depression (PHQ9) if they have been bullied.

The is also an interesting question in terms of any particular forms of bullying that could be associated with the development of OCD and MC. Although the researcher believes psychological bullying maybe correlated with MC, at this stage, this is very much exploratory research.

Methods

Ethics

Ethical approval was obtained through the ethics committee at the University of Bath on 11/02/2015, approval number 14-248.

Participants:

Recruitment for the current study was challenging due to the nature of the sample. The researcher recruited 73 participants via Social Media and the charity OCD-UK. The age range was 17-68 years, 14 were male and 59 were female, and 20 had been diagnosed with OCD, the other 53 were healthy controls. Of the 20 individuals diagnosed with OCD, 16 indicated that they had experienced bullying, and of the other 53 participants, 11 reported bullying. The excluding criteria was participants had to be over 17 years of age, due to requiring qualifications to treat patients, and could not have a history or symptoms relating to psychosis.

For ethical reasons, all individuals had to be over 17 years to take part in the study. There were no exclusion criteria as the study required participants both with and without experiences of bullying, and diagnoses of OCD.

Materials and Equipment:

The current study was based on questionnaires, which were both qualitative and quantitative in nature. A demographic sheet was used to collect information such as age, gender, etc (see appendix 14). A self-report version of the Structured Interview For DSM IV (SCID) was included in the study to generate information about their obsessive and compulsive symptoms (see appendix 16). There were two specific questionnaires based on experiences of bullying, these were only

included in the pack if individuals indicated that they had such experiences. The rest of the questionnaires covered various topics including obsessive and compulsive tendencies, contamination fears, anxiety and depression, disgust, betrayal, sensitivity to social put-downs, shame, (see appendix 3-23).

(i) *The Bullying Experiences questionnaire*: was developed by the current researchers for this study. It was largely based on the research and questionnaire produced by Olweus (Olweus 1996, Solberg and Olweus 2003). However, the author produced this scale so he could ensure the language was both friendly and accessible, easy to complete, and items were more relevant to the current research questions. It contained 68 items with a combination of tick boxes, Likert scales, and boxes for written answers. This combination was used to collect as rich and detailed information as possible. The survey revolved around the experiences of bullying during school, the different types of bullying that an individual may have encountered, the frequency of the attacks and questions relating to how the experiences affected their lives at school and during adulthood.

In terms of psychometric properties, the questionnaire is descriptive rather than a continuous scale, psychometric information such as internal consistency would not be appropriate. The fact that items were completed by a variable subset of participants made any detailed psychometric analysis impossible.

(i) *The Obsessive-Compulsive Inventory (OCI, Foa, Kozak, Salkovskis, Coles, & Amir, 1998)*: has been incorporated to measure for OCD, and is widely regarded as the most effective at measuring obsessive-compulsive symptoms in general. There has been a revised version, the OCI-r (Foa, Huppert et al. 2002) but it is much shorter and therefore may miss valuable data. Of importance, the OCI yielded a test-retest reliability score of at least .68 ($r = .68$), with the majority of the subscales exceeding .80 ($r = .80$). Internal consistency also scored highly with a range of .86 - .95 (Foa, Huppert et al. 2002).

(ii) *Vancouver Obsessive-Compulsive Inventory-mental contamination (Thordarson, Radomsky et al. 2004):* the original VOCI has been frequently employed in other investigations surrounding OCD due to its high internal consistency ($\alpha = .96$). Furthermore the scale also contains high convergent and divergent validities (Radomsky, Ouimet et al. 2006). It is important to note here that the mental contamination element of the VOCI has not been validated in terms of validity and reliability, as it is a recent edition that has not been used. The VOCI-MC is a much shorter questionnaire, only consisting of 20 items, because it focuses on mental contamination. Items include; “often I look clean but feel dirty”, “I often feel dirty under my skin”, “if I

experience certain unwanted repugnant thoughts, I need to wash myself", so the questions are relevant to the current study.

(iii) *The Patient Health Questionnaire-9 (PHQ-9, (Kroenke and Spitzer 2002):* this is a brief scale to explore and measure depression in patients or participants in research. It is frequently used in the literature, has high internal reliability of .89 (α=0.89), and also has excellent test-retest reliability.

(iv) *Generalised Anxiety Disorder-7 (GAD-7, (Spitzer, Kroenke et al. 2006):* this scale aims to explore anxiety in general, and the findings are often related to GAD. The scale scored .83 (r=.83) in terms of test-retest reliability and has high convergent validity. Six of the seven items on the scale also score highly in divergent validity.

(v) *Questionnaire on bullying and guilt* – this scale consists of 2 parts: section A contains 21 items exploring various aspects of the experiences of bullying, including reactions, feelings, causes, consequences, and preventative measures. Section B lists 11 emotions or feelings (including contamination) and the participants have to rate them 0-100 in terms of the memories of the bullying.

(vi) *Scid* – this is designed to explore the basics of the individual's OCD, from age of onset, to seeking help, whether they are receiving treatment etc. This has been included because it may highlight interesting associations during the analysis process.

(vii) *RIQ* – this tool asks participants report their last 5 intrusive thoughts. The researcher has included this to investigation any particular relationships between types of bullying and intrusions.

(viii) *Beliefs* – this is a 16 item Likert scale revolving around the individual's beliefs about their intrusive thoughts. The participant has to rate each statement out of 100 in terms of how true the item is.

(ix) *RAS (Salkovskis, Wroe et al. 2000)* – is a 26 item scale designed to investigate the idea of an inflated sense of responsibility. On each item the participant has to indicate how strongly they agree with the statement. The scale is high in reliability and consistency, scoring .94 (r=.94) and .92 (α=.92) respectively (Salkovskis, Wroe et al. 2000).

(x) *Disgust-r (Olatunji, Williams et al. 2007)* – this is a revised 25 item scale exploring core disgust, animal disgust and contamination disgust, all of which are associated with OCD and MC. This scale also scored high in consistency at .88 (α=.88) but because the questionnaire

investigates 3 different areas of disgust, it is difficult to give an overall validity score. However, validity was improved compared to the original scale (Olatunji, Williams et al. 2007).

(xi) *Experience of shame (Andrews, Qian et al. 2002)* – a 25 item scale that investigates 3 forms of shame: characterological; behavioural; and bodily. The scale is high in reliability and consistency, scoring .83 (r=.83) and .92 (α=.92) respectively (Andrews, Qian et al. 2002). The researcher has included this tool to explore the relationship between sense of self and MC.

(xii) *Sensitivity to social put-downs (Gilbert and Miles 2000)* – this is a 20 item questionnaires that explores anxiety, distress, anger, and irritation in relation to social put-downs. Again, this scale is useful for examining the sense of self aspect of MC.

(xiii) *Betrayal impact scale* – a 42 item questionnaire exploring 4 different areas of betrayal: preoccupation with betrayal; trust; trauma-related betrayal; and trust. The researcher included this scale because betrayal seems significant in the theory of MC.

Procedure

Before the participants received the study pack, they had the opportunity to read an information sheet that described the study (see appendix 28). The form highlights what is involved in the study, why the researchers are performing such an investigation, and what is expected of the participant. The form also reminds each participant that they can withdraw their data from the study at any time by emailing the researcher. If the individual is happy, they identify the pack required (OCD/not OCD, bullied/not bullied) and the researcher posts the pack accordingly (see appendix 3-23). Every pack has a consent form on top, which must be completed for the data to be used. Once this has been completed, the participant can return the pack using the free-post address provided by the University of Bath to avoid a charge. Finally, participants are then emailed a de-brief sheet that contains more information about the study, as well as the contact details of the researcher (see appendix 29). At that stage, each participant had the opportunity to ask as many questions as they liked.

Data analytic strategy

This study can be divided in to two sections: quantitative; and qualitative; which are analysed with different techniques.

SPSS will be used for the entire quantitative data set. Tests such as t-tests, ANOVAs, ANCOVAs and correlations will be conducted to investigate differences between the four groups of participants. Considering the research questions outlined above the scores of the above scales can be compared. In particular, the author is interested in whether there are any differences in the

experiences of bullying reported by individuals with and without OCD. Whether particular types of bullying are more associated with OCD (the development of, or individuals diagnosed with).

Experiences of betrayal will be measured using 2 different approaches. The Betrayal Impact Scale (mentioned above, see appendix 23) will analyse the phenomena from a quantitative perspective, calculating answers to particular items to generate scores for the 4 subscales. The Bullying Experiences Questionnaire will also examine betrayal but from using qualitative methods. Some items were designed to explore the ways in which friends and family reacted to the bullying. If these individuals were not seen as supportive, or sided with the bully, the participant may report experiences of betrayal.

To analyse the qualitative section of this study the researcher will use thematic analysis and follow the procedure described by Braun and Clarke (Braun and Clarke 2006). The author considered reliability, validity, and rigour in relation to qualitative research throughout the study by using the 15-point checklist created by Braun and Clarke.

To begin with, the researcher familiarised himself with the data by reading each item of the questionnaire and verbal responses several times before collating all these answers in to a single Word document. This further familiarises the author with the data, which is then more manageable to have all the qualitative data on screen in one file. The document was checked twice to make sure every comment had been inputted. At this point the data was sent to another researcher, Professor Salkovskis, supervisor and clinical psychologist with significant experience both researching and treating individuals with OCD. The analysis was conducted by two people with different perspectives, improving the study's validity, reliability and internal consistency (Tuckett 2005, Fereday and Muir-Cochrane 2006).

Following Braun and Clarke's approach, the data was broadly coded, line-by-line, to generate main features for each item of the survey. These codes were developed relating to the general meaning of the comment rather than the vocabulary used. These codes provided the basis for further analysis. Codes were not necessarily one per written response; some answers could be split into multiple themes.

The researcher then reviewed the codes again and in some instances, they were extremely similar, so they were merged into larger themes. Drawing a thematic map helped in this process. During the development of the themes, the researcher frequently examined the original data and the participants quotes to ensure the themes fit with the data.

Once both researchers had reached this stage, they then met to discuss the coding and themes. There were themes that were re-worded to incorporate the input from both individuals, which was simple because the themes produced by the two

individuals were similar. suggesting there was a degree of internal consistency between the two researchers (Tuckett 2005, Fereday and Muir-Cochrane 2006).

Themes were further defined and strengthened by using quotes. The author started by collecting quotes for each item – they would be included in the main overarching themes. For validity and reliability reasons the researcher collected quotes from as many different participants as possible. The author began with the individuals who were less expressive with their written answers, so if relevant, their answers could be used as quotes. The more expressive participants were quoted for items and codes where the answers were more sparse.

Finally, the researcher analysed each theme for clarity and consistency, and made sure the theme descriptions fitted with the meaning in the original data and participant quotes. When writing the report, the main researcher selected quotes for each theme. For validity and reliability reasons, it was important to select quotes from as many different participants as possible. The quotes were used to illustrate each theme.

Results

Participants

The researcher recruited a total of 73 participants but had to subsequently exclude 6 participants from the analysis. 1 participant was removed because she had completed less than half of the questions in the research pack. A second individual was excluded because she indicated that she had been diagnosed with OCD, but she was unable to complete the questionnaire on intrusive thoughts (possibly because she didn't have any), and she scored nearly all '0' on the OCI, VOCI, GAD7, PHQ-9.

Unfortunately, a further 4 participants had to be excluded; in correspondence they had all indicated that they had not experienced any form of bullying and therefore received the study pack without the questionnaires on bullying. However, when receiving the pack, the participants had ticked 'yes', suggesting they were bullied, but had not completed the bullying questionnaires. The researchers were unable to allocate them the bullied or non-bullied group, so the data were removed.

It should also be noted here that some participants had missing data when returning the packs. In the most extreme case, one participant missed out the whole demographics questionnaire. The data was included in the analysis because these participants had completed most of the study pack.

Sample distribution

The study ran for over 3 years but unfortunately the researcher was only able to recruit 73, resulting in a working sample of 67 participants. When analysis began, the researchers expected difficulties working with such a small sample. We were surprised to note how few of those with OCD had NOT been bullied, so this

association was analysed using a chi-sqaure test. This analysis found a significant association between having OCD and being bullied (χ^2 (1, N = 67) = 20.7, p < 0.001). In the control group 32 participants had not experienced bullying compared to 11 who had, but only 4 individuals diagnosed with OCD had not shared the same experience; this means 80% of participants with OCD had experienced bullying. This of course is consistent with the view that bullying may impact the development of OCD and MC, but also meant that there were not sufficient numbers to perform the planned analysis.

The originally planned analysis was to utilise all 4 participant groups in a factorial design using ANOVA on MC. The researchers aimed to perform, but this was clearly not possible with the important OCD and not bullied group being so small. Instead, we have had to restrict this aspect of the study to a descriptive analysis of means and standard deviations for both participants with or without a diagnosis of OCD, and with or without experiences of bullying. Table 4 displays descriptive statistics for scores on the key questionnaires used in this study.

Table 3: Means & standard deviations for both participants with or without a diagnosis of OCD, and with or without experiences of bullying, in relation to key questionnaires.

Questionnaire	OCD				No OCD			
	Bullied		Not Bullied		Bullied		Not Bullied	
	Means	SD	Mean	SD	Mean	SD	Mean	SD
OCI Washing	9.1	8.9	11.5	11.6	1.5	2.8	2.6	2.4
OCI Checking	11.6	8.1	10.3	10.1	4.6	7.1	4	4.1
OCI Doubting	5	4.2	3.3	5.3	1.2	1.8	1.8	2.6
OCI Ordering	5.6	4.8	4.5	8.3	3	4.4	3.1	3.5
OCI Obsessions	15.2	8.7	16.3	11.3	4	6	3.8	4.1
OCI Hoarding	3.2	3.8	3.3	3.2	1.9	2.8	2.4	2.6
OCI Neutralising	7.1	6.1	3.3	4.3	1.9	2.6	2.3	2.5
OCI Total	56.7	28.1	52.3	37.7	17.9	21	20	15.1
VOCI-MC Total	19.6	18.1	15	12.8	3.6	6.2	2.8	4.2
GAD7 Total	11.2	4.9	11.8	10.9	7.5	6	6.8	6.3
PHQ-9 Total	8.7	5.4	9.3	8.3	7	7.7	6.6	6.3
Disgust Core	21	4.5	22.3	5.4	15.1	9	20.7	4.8
Disgust Contamination	6.8	2.1	8.3	2.6	4.5	3.1	6.5	2
Put-Downs Anxiety Total	65.5	27.3	71.8	20.2	64.6	28.4	58	28.2
Put-Downs Anger Total	67.9	15.8	56	5	55.1	31.8	58.6	19.9
Betrayal Preoccupied	33.8	11.6	30.3	15	25.9	16.5	27.8	14.7
Betrayal Trust	26.1	8.2	22.8	13.5	18.7	11.6	19.7	10.6
Betrayal Trauma	13.7	5.5	11	4.1	12.3	7.3	10.8	6.2

Table 4 illustrates in most cases participants who have been diagnosed with OCD and have experienced bullying scored higher on questionnaires compared to the rest of the sample. VOCI-MC scored are considerably higher in the condition too, consistent with the notion that bullying is linked with MC. The total OCI scores are considerably higher in the same group, suggesting a relationship between bullying and OCD in general. However, although the statistics indicate there are such links, with the sample size and distribution, the researcher cannot perform any further analysis to support these suggestions.

Descriptive statistics in terms of the types of bullying experiences for both individuals with OCD and the control group are shown in Table 5 below, which shows the percentages of bullying experiences for the two groups.

Table 4: A list of descriptive statistics in relation to the bullying experiences for both the OCD sample and control group

Question	OCD	No OCD
Physical bullying		
Struck	38%	44%
Substance	19%	22%
Belongings stolen	38%	78%
Pushed	56%	44%
Age bullied		
-6 years	7%	25%
7-9 years	13%	38%
10-12 years	47%	25%
13-16 years	27%	27%
Frequency		
Daily	8%	11%
Weekly	8%	22%
3x week	39%	11%
Monthly	31%	56%
Duration		
Day	15%	9%
Week	20%	27%
Month	5%	36%
1 Year	20%	0%
Multiple years	10%	9%
Bully was same age	87%	89%
Bully was older	33%	33%
Bully was younger	7%	0%
Bully was a friend	53%	33%
Verbal bullying		
Name calling	84%	90%
Bullied because of people you associate with	37%	30%

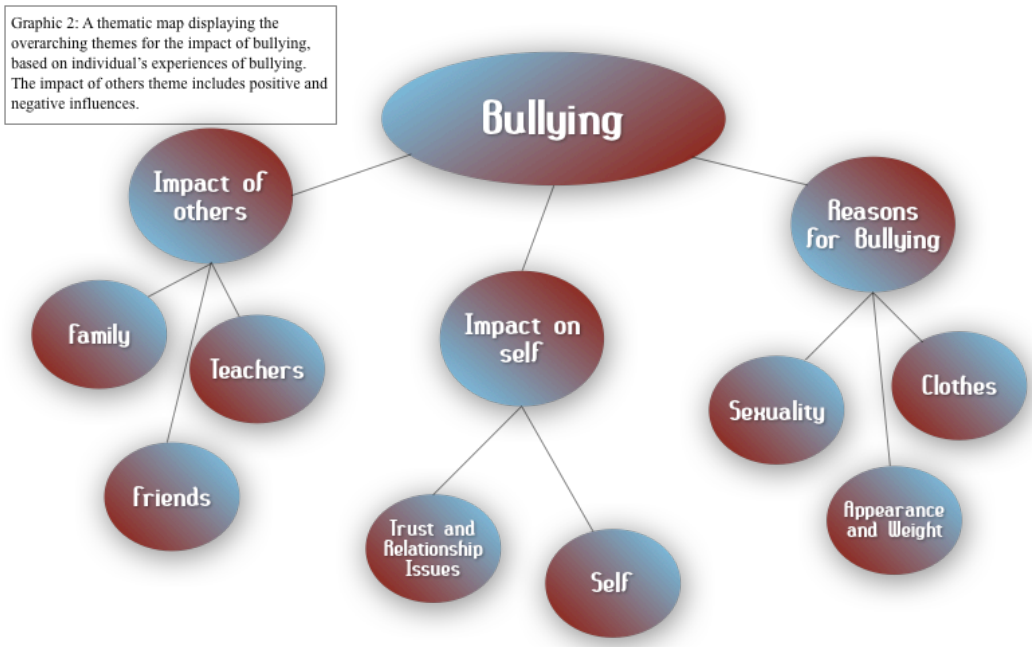
Bullied because of things you do	53%	50%
Bullied because of your sporting ability	26%	10%
Bullied because of your school ability	16%	30%
Bullied because of your social ability	58%	60%
Age		
-6 years	0%	30%
7-9 years	33%	50%
10-12 years	56%	20%
13-16 years	11%	0%
Frequency		
Daily	47%	0%
Weekly	29%	40%
3x a week	24%	50%
Monthly	0%	10%
Duration		
Day	10%	9%
Week	30%	36%
Month	10%	27%
Year	20%	0%
Multiple years	30%	27%
Bully was same age	94%	90%
Bully was older	39%	30%
Bully was younger	17%	20%
Bully was a friend	39%	50%
Psychological bullying		
Rumours	55%	56%
Ignored	60%	78%
Friends turned against you	65%	67%
Age		
-6 years	6%	22%
7-9 years	17%	33%
10-12 years	50%	44%
13-16 years	22%	0%
Frequency		
Daily	36%	22%
Weekly	14%	11%
3x a week	29%	56%
Monthly	14%	11%
Duration		
Day	5%	0%
Week	40%	46%

Month	5%	9%
Year	5%	0%
Multiple years	30%	27%
Bully was same age	90%	89%
Bully was older	32%	11%
Bully was younger	5%	11%
Bullied by a friend	74%	78%
Other questions		
Who did you tell?		
Nobody	42%	30%
Parents	58%	70%
Teacher	26%	30%
Friend	21%	20%
Parent reactions		
Supportive and helpful	79%	50%
Critical of child	0%	1%
Critical and agreed with bully	0%	0%
Friend's reactions		
Friends were supportive	44%	30%
Friends began bullying	19%	30%

Inferential statistical testing was not carried out on this data set due to small numbers and awkward sample distribution. Simply visually comparing the percentages of the 2 groups suggests that overall there are few differences, suggesting that the pattern of bullying experienced by those with OCD was similar to those who did not have OCD. For example, equally high numbers of participants reported experiencing name calling in each group. Similarly, relatively low numbers indicated they may have been bullied by a younger student. The only slight difference worth noting, across all 3 forms of bullying (physical, verbal, psychological), individual may have been bullied at a later age then controls.

Thematic analysis

With the use of Braun and Clarke's Thematic Analysis (Braun and Clarke 2006) the researchers were able to develop 3 overarching themes. Graphic 2 below displays these themes in a mind-map format.



Graphic 2: A thematic map displaying the overarching themes for the impact of bullying, based on individual's experiences of bullying. The impact of others theme includes positive and negative influences.

Impact of others

The first overarching theme revolves around how other people can influence the victims' experiences of bullying. This can be a positive impact in terms of how supportive other individuals are throughout the traumatic incident. This theme also includes the negative reactions of others towards the bullying.

Family – A number of participants who had experienced bullying discussed the role of family members during the traumatic incidents. Parents and siblings are often the closest individuals to the victim so the way they react can have a significant impact.

Positive

P43: "Parents were wonderful"

P47: "Mother intervened with the physical bullying as she saw my blazer was torn and I had a mark on my face"

P59: "Dad was going to speak to boys parents but I didn't want him too"

Negative

P47: "During my early years at primary school I developed bed wetting. This went on for several years. My mother would lose her temper with me for this and smack me. Because of this I would lay in a wet bed and not tell her"

P5: "My dad bullied me. He is at least a very difficult person – he has a very short fuse and temper and he constantly put me down & made fun of me. He would have thought it hilarious sadly and would of told me off for being pathetic"

P58: "Felt they wouldn't be supportive or would agree with the bully"

These positive comments represent the support network that an individual requires when experiencing trauma. However, there seemed to be more negative reactions which is in line with the authors hypotheses and the role of betrayal in MC.

Teachers – Similarly, teachers are characters within the school environment who children see as authoritative and may provide an element of protection. It is unsurprising then, that participants discussed the role of the teacher to such an extent that the analysts produced a sub-theme regarding their impact.

Positive

P23: "Teacher intervened w/ primary cyber bullying"

P8: "after the desk lid incident the bully was moved so she no longer sat next to me – after 3 years of bullying"

Negative

P43: "Head teacher responded by saying bullying didn't exist in his school"

P2: "Teachers didn't believe me because there were more bullies denying version of events and I was new"

P2: "My parents repeatedly tried to talk to the school but the teachers told them I must be the one at fault because the other kids had been at the school longer, and according to them, the word "GAY" had never been uttered at the school before"

P12: "There was one teacher who pretended I didn't tell him and ignored me but the rest were fine"

As with the 'family' sub-theme, teachers provoked positive and negative comments from participants who experienced bullying. According to the preventative act as outlined in chapter 3, the teacher should play a role in reducing instances of bullying; two participants clearly suggest that the teachers helped. However, there are instances where the teachers have been less supportive and have actually denied the fact that bullying occurs in their school. This may be due to a number of reasons, including guilt, shame, and fear of legal prosecution. It would be much more beneficial to the school as a whole, and the victim personally, if the teachers would accept the situation and do more to reduce bullying, ensuring other students avoid such traumatic experiences.

Friends – The role of friends was important in this study to further investigate the influence betrayal has in MC. The literature also highlights how bullying can be reduced, or exacerbated depending on the involvement of friends (Boulton, Trueman et al. 1999, Crick and Nelson 2002, Mishna, Wiener et al. 2008). The majority of participants in the data set made comments about how friends affected their experiences of bullying.

Positive
P8: “Teenage friends were protective”
P16: “Some joined in/some were supportive”

Negative
P2: “I was new at the school so did not have any established friendships made some friends but they didn’t do anything”
P5: “I can understand why as they could have been picked on too”
P11: “Did not want to become involved”
P50: “A lot of the time it was my friends who were doing the ‘bullying’”

Some participants were lucky enough to have friends who supported, and in some instances, protected the victim from the bullying. It’s possible that more friends may have been supportive if they had not been bullied themselves. Several participants mentioned how their friends were actually the bully. This may be to be liked, to gain status, or possibly to avoid being bullied. In this study there was no mention of being bullied because of their circle of friends. The individuals may have experienced a feeling of betrayal, although this was not mentioned in this study either.

The author feels it is important to note here how significant the ‘friends’ theme is in this study. Most of the participants mentioned the role of friends, positive or negative, and these commented were found throughout the questionnaire. This might emphasise the importance of a support network as well as how intense bullying can be when one’s own friends are involved.

Impact on self
In chapter 3 of this thesis the author discussed the role of the self in the development of MC. The fact that the analysts were able to develop an overarching theme revolving around the self, based on the comments of a broad number of participants, supports this premise. 2 individual sub-themes were constructed here

Trust and relationship issues – The researchers found some participants reported that experiencing bullying had impacted the way they perceived others. Not only did they comment on their ability to trust others, but they struggle to form and maintain meaningful relationships.

P12: “I never been in an intimate relationship but I’m only starting to gain trust in males (the bullies were male)
P9: “Ongoing difficulty forming relationships”
P11: “I have only had 1 relationship and consider it to be successful (36 yrs)”
P2: “I think I find it hard to trust because of me experience. I do not find it difficult to form friendships and once I judge someone to be trustworthy I have little difficulty opening up. I think this trust issue impacts on my confidence at times”

Unsurprisingly trust and forming relationships seem to be interlinked and most participants discuss the two together. The school environment is unescapable so unless the victim manages to change schools (which does not always help), bullying can be an everyday occurrence involving multiple perpetrators. This must affect the ways in which these individuals view others and seems to have a knock-on effect on forming relationships. In the quote above, P2 suggests that once trust has developed, relationships can follow. Individuals who have experienced bullying may benefit from trust workshops.

Self – The second sub-theme revolves around the self in a much broader manner. A person's sense of self is a huge concept and participants' comments revolved around so many different aspects of the self.

P52: "Made me feel bad about myself"
P60: "Yes, low self esteem"
P60: "Blamed myself for being unlikable"
P65: "I believed I was stupid"
P69: "I definitely lost a lot of confidence"
P69: "I always expect not to get recognition for my positive achievements"

Comments relating to the victims' self-esteem and confidence were reported by several participants. This should be expected when one considers the verbal and psychological forms of bullying. As a result, it seems some participants blame themselves and expect to be treated negatively by others.

A similar theme was developed in study 2 which explored therapists' attitudes towards the relationship between bullying and mental health difficulties (see chapter 5). Both studies yielded comments about self-esteem, self-blame, expecting to be treated negatively by others. The key difference is that the therapists' comments were in more detail. The participants may have answered in more detail in an interview rather than written answers in a questionnaire.

Reasons for bullying

In terms of why individuals were bullied, the participants in this study seemed happy in explaining why they felt they were a target for bullying. This particular item on the questionnaire yielded a great deal of answers, to the extent that the third overarching theme to accommodate these comments.

Appearance and weight – One of the main reasons why participants believe they bullied revolves around the individuals' appearance and/or weight. This seems an obvious reason for the bully and therefore is reported more in the section for verbal bullying.

P4: "Ginger hair so a lot of name calling"
P16: "Bullied for being smart/ugly"

P23: “As a teenager, nicknamed after an unattractive character in a sitcom”
P59: “eczema covering 80% of my body surface area”
P28: “Called whale”
P60: “Avoided because of my size”
P72 “Comments relating to my weight, breasts, skin colour”

This can affect an individual’s self-esteem, which can affect the individual’s life in general. A lack of confidence can affect everything from education, occupation, to the ability to form relationships. This is a key reason to why psychologists and other therapists need to understand the impact of bullying and preventative measures in place to help children avoid such traumatic experiences.

Clothes – A number of participants felt they were bullied because of the clothes that they wore. This may be due to the style of clothes, the fact that they were old, second hand and did not fit correctly, or cleanliness.

P5: “We didn’t have much money and lots of my stuff was second hand or very cheap + unfashionable + I stuck out from others”

This may be related to social rank in that bullies may realise that the family struggle financially and bully the children as a result. Further, this may reaffirm the status of the bully, reminding the victims where they sit in the social hierarchy.

Sexuality – The researchers found that a number of participants felt they were bullied due to their sexuality. In some cases this maybe in the form of verbal bullying, in other individuals mentioned it in the psychological bullying section.

P2: “Name calling (not appearance-related) - mostly being called ‘GAY’”
P69: “Making up rumours that I was a lesbian”

It is important to note here that the researcher is unaware of the participants’ sexual orientation so these could be heterosexism acts or simply using homosexuality as a derogatory term.

Discussion

The researchers designed this study to investigate the ways in which experiences of bullying interacts with the development and symptomology of OCD, and in particular, MC. The literature associates bullying with depression, anxiety, body dysmorphic disorder and eating disorders (Batsche and Knoff 1994, Olweus 1996, Kumpulainen, Räsänen et al. 1998, Kaltiala-Heino, Rimpelä et al. 1999, Baldry 2004, Camodeca and Goossens 2005), but it has not been linked to OCD in any way.

In relation to the specific experiences of bullying, there was evidence of similarities between groups in terms of the types of bullying, frequency of attacks, or the duration of the victimisation between the two groups of participants. There

were also few differences in the ways individuals reacted to the bullying. However, it is of note that the study found that 80% of the participants who had been diagnosed with OCD reported experiencing bullying. Unfortunately, due to the size and distribution of the sample, the researchers were unable to perform any form of quantitative analysis. Although descriptive statistics indicated some subtle differences in terms of questionnaire scoring, the sample was inadequate for detailed analysis.

The researchers used Thematic Analysis to work on the qualitative data, yielding three overarching themes. The first focusses on the ways in which other individuals (parents, teachers, friends) can impact bullying; positive and negative. The second revolves around how bullying affects the victims sense of self, trust and relationships. Finally, the third overarching theme focusses on the reasons for bullying, with the subthemes sexuality, clothing and appearance & weight.

Hypotheses & empirical research

Due to sample size and distribution, the researchers were unable to perform any statistical analyses, and were therefore unable to test any of the hypotheses. Descriptive statistics do indicate differences between the two groups in terms of OCD and MC, but these differences were not analysed scientifically. Due to these reasons, the study was unable to support any research that links MC with feelings of betrayal, humiliation or degradation (Rachman 2010, Coughtrey, Shafran et al. 2011, Warnock-Parkes, Salkovskis et al. 2012).

We were unable to analyse betrayal using quantitative methods due to problems with sample distribution. However, the thematic analysis developed two themes relating to the reactions and behaviour of family & friends, and trust & relationship issues. Participants discussed ways in which their family were supportive, “parents were wonderful”, but many discussed them in a negative manner, “mum said I would end up in a mental hospital”, “mother become angry for bed wetting, she would hit me”. A frew individuals also discussed how they felt protected by their friends, “teenage friends were protective”, “friend confronted the bully”, but again, a number of individuals discussed how their friends turned on them, “all three bullies were good friends of mine”, spread rumours, “rumours spread by close friend”, and some of their social groups becoming bullies, “within friendship group”.

In terms of trust and relationships, participants commented “I find it harder to trust because of my experience” and “I never been in an intimate relationship but I’m only starting to gain trust in males (the bullies were male)”. Although the participants in this study did not specifically use the word ‘betrayal’, many spent time discussing these issues in relation to their experiences of bullying. It is plausible to suggest many of these individuals, if not all of them experienced betrayal to some degree. This is consistent with the literature and the theory that betrayal is significantly involved in the development of MC (Freyd 1994, Rachman 2004, Rachman 2006, Rachman 2007, Rachman 2010, Warnock-Parkes,

Salkovskis et al. 2012, Millar, Salkovskis et al. 2016, Pagdin, Salkovskis et al. In press).

Limitations

The main limitation is the small sample size. The study ran for over three years, the researcher used twitter, OCD-UK, his blog, and the university research page to recruit participants and yet only 73 individuals took part and completed the questionnaires. NHS ethics was avoided due to time constraints of the PhD programme, but in hindsight, the study may have collected more data if this form of recruitment was used.

Along with small sample size, the study's key weakness was the sample distribution. The group of individuals who did not have a diagnosis of OCD was fine, but in the OCD group 80% of participants reported experiences of bullying, this meant that only 4 individuals had not been bullied. These numbers are clearly not sufficient for any form of science analysis. The researchers were unable to test any of their hypotheses, unable to explore differences in a sample of individuals with OCD who had been bullied and those who had not, and the study was unable to produce any meaningful conclusions.

Conclusion

The study was designed to investigate links between bullying, OCD and MC, and to investigate whether or not types of bullying differ in relation to the disorder. Descriptive statistics indicate individuals who have experienced bullying score significantly higher in terms of MC, obsessive and compulsive tendencies, anxiety and depression. They also show no significant differences in terms of the experiences victims endure while being bullied. The researchers were unable to explore the relationship between MC and betrayal or degradation.

The key findings are that most participants with OCD in this study had experienced bullying (80%), suggesting an association between the two. Further, the fact that the study found no significant differences in terms of experiences of bullying suggests an underlying mechanism that causes some individuals to become more susceptible to OCD and MC, and bullying may be a stimulant that triggers obsessive problems. The researcher will now discuss the PhD as a whole, including the findings of all 3 studies.

Chapter 7 – Discussion

Obsessive-compulsive disorder (OCD) is now a specific category within the "obsessive-compulsive and other related disorders" grouping in DSM 5 (American Psychiatric Association 2013), having previously been considered a type of anxiety disorder in previous editions (American Psychiatry Association 2000). The change is attributable to the adoption of the concept of "Obsessive compulsive spectrum" (Hollander and Stein 1995) and has resulted in several other conditions being grouped with OCD such as hoarding disorder and body dysmorphic disorder (BDD), on the basis that they involved repetitive or compulsive symptomology (American Psychiatric Association 2013). However, there has been no convincing demonstration that anxiety is less relevant in OCD relative to other disorders within the anxiety disorder group. Neither has there been any convincing demonstration of common factors underpinning the so-called obsessional spectrum. In general, the value of diagnosis and diagnostic groupings relates to notions of shared phenomenology, maintaining processes and etiological factors.

In terms of phenomenology, OCD is characterised by *obsessions* which are repetitive intrusive thoughts, images or urges, and *compulsions* which are neutralising behaviours or cognitive acts that must be rigidly performed in response to the obsession. A common symptom is fears of contamination that now comes in two forms; contact contamination (CC), which is the well-known, stereotyped feeling dirty, resulting in compulsive cleaning, and a relatively new concept, mental contamination (MC), which is an internal form of pollution. Due to its cognitive nature, Rachman has suggested that researchers and clinicians may need to take a different approach to that taken with CC to further our understanding and develop effective treatment of MC (Rachman 2004). It is the putative link between bullying, this internal form of dirtiness and OCD that has been the focus of this thesis.

The theory of MC is still in its early stages and there is still much that needs investigating. This form of contamination fear is cognitive in nature, and there are reasons to believe that it is strongly linked to memories (associations) with unpleasant past events, particularly those involving betrayal and degradation. Simply, feeling dirty may be linked to the sense of having been treated like dirt. MC can be provoked by thoughts, memories, urges, accusations, violations and is associated with considerable anxiety and distress. It also motivates intense neutralising behaviours including physical washing, although these seem to be mostly ineffective, probably because of the internal nature of MC (Rachman 2004, Herba and Rachman 2007, Elliott and Radomsky 2009, Radomsky and Elliott 2009, Coughtrey, Shafran et al. 2011). However, they also appear to be extreme and persistent, and at times may border on self-harm (e.g. we are aware of sufferers who have drunk and injected undiluted bleach). In some instances, these behaviours may function similarly to non-suicidal self-harm; that is, as a distractor from painful memories and emotions.

Research suggests MC is highly associated with immoral behaviour and believing mistreatment has occurred (Fairbrother and Rachman 2004, Rachman 2004, Fairbrother, Newth et al. 2005, Rachman 2006). It may be that the person experiencing MC believes their anxiety to have been mitigated by their physical washing; that is, they would have felt worse had they not done so. Surprisingly, MC can be experienced by both the victim of a form of traumatic violation, and the perpetrator who is behaving immorally (Rachman 2004, Rachman, Radomsky et al. 2012); this of course was the case in Lady Macbeth's washing following her encouraging her husband to murder the king.

Some but not all previous research suggests that MC is related to feelings of betrayal, degradation, humiliation, and attacks on the individuals' sense of self to some degree. The author contemplated what traumatic incidents could result in the development of unpleasant associations between objects which are regarded as "contaminated" and memories, including dirt but extending to other stimuli which resemble those involved in the original trauma or traumas, and therefore may be a cause of MC. Experiences of bullying were identified as possibly having the potential to trigger feelings of MC for a few different reasons. This form of trauma is known to be commonly associated with a sense of degradation and humiliation. Research also suggests that bullying can cause high levels of anxiety and depression (Craig 1998, McCabe, Antony et al. 2003, Baldry 2004). This common and unpleasant form of personalised victimisation has the possibility of causing feelings of betrayal in the reactions of family and friends (we have certain expectations of these individuals, so if they do not support the victim sufficiently, or seem to side with the bully, this could trigger betrayal), or the bully may feel a sense of betrayal as their aggressive behaviour may conflict with their sense of self or their moral system.

Clearly, bullying is a type of abuse which can be considered a traumatic experience. The Oxford dictionary defines abuse as "Treat with cruelty or violence, especially regularly or repeatedly" and bullying as "A person who uses strength or influence to harm or intimidate those who are weaker" (Oxford Dictionary, 2003). Both definitions are similar, although the latter uses the term 'weaker', as in, the bully seems to have more power or status and is therefore able to attack their victim. This is consistent with the third study in this programme that found victims were rarely bullied by younger individuals.

This idea of bullying being a negative act where the larger or more influential (possibly due to status) perpetrator inflicts harm (physical, verbal or psychological) on the 'smaller' victim, creates the stereotype that bullying is an experience that occurs in schools. As a result, there seems to be a lack of research connecting experiences of bullying with psychological disorders, beyond the more obvious anxiety, depression, and eating disorder work (Craig 1998, Kaltiala-Heino, Rimpelä et al. 1999, McCabe, Antony et al. 2003, Baldry 2004, Janssen, Craig et al. 2004, Wolke and Sapouna 2008).

Research

This PhD is based on the notion that experiences of bullying may influence the development of MC. So, this raises various questions. Do individuals who report being bullied score higher in OCD and MC-related questionnaires? Further, to be consistent with the current literature, do these individuals also score higher in terms of anxiety and depression? If the sample consists of participants with a diagnosis of OCD, do they score high in betrayal or sensitivity to social put-downs. Do these individuals experience different forms of bullying compared to those without OCD? These questions can directly relate to the theory of MC.

The link between bullying and mental health difficulties has not been extensively researched, so individuals who treat patients with psychological disorders may not be aware of such a relationship. Do therapists agree that there is a link? Do they consider bullying experiences when taking on new patients? Do they target bullying at all, in the therapy setting? As there are so many questions, the researchers designed three studies exploring the relationship between bullying, OCD and MC from different perspectives.

The first (chapter 4) was an initial investigation using a general population sample. Participants were divided into two groups depending on whether or not they had experienced bullying, and the researcher hypothesised that those individuals who had reported experiences of bullying would score higher on questionnaires revolving around OCD, MC, anxiety, and depression. The study results were consistent with all these predictions; participants did score significantly higher on this questionnaire, individuals scored significantly higher in terms of OCD and MC, even when the researchers controlled for the effects of anxiety and depression. Similarly, participants who reported bullying score significantly higher on obsessions and neutralising behaviours (the OCI subscales), even when anxiety and depression are controlled for.

Firstly, this study is consistent with the literature that suggests bullying provokes feelings of anxiety and depression (Craig 1998, Kaltiala-Heino, Rimpelä et al. 1999, Camodeca, Goossens et al. 2002, McCabe, Antony et al. 2003, Camodeca and Goossens 2005, Kim, Leventhal et al. 2006). The significantly higher scores on the OCI and the VOCI-MC are consistent with the notion that not only is bullying connected to MC, there is also a relationship with OCD to some degree. Sub-scales of the OCI, including obsessions, neutralising behaviours, and hoarding, were all significantly higher in the bullied group compared to the non-bullied group.

The second study (chapter 5) considered the link between bullying and OCD from a different perspective by investigating therapists' attitudes towards the relationship between bullying and mental health difficulties, not just OCD and MC. Whether therapists believed experiences of bullying could cause the development of psychological disorders, may support the author's theory that

bullying can influence fears of MC. It could also provide knowledge in terms of how regularly therapists consider bullying as a potential issue when treating patients.

Although individuals differed in the strength of the relationship, every participant agreed that bullying can influence the development of psychological disorders to some degree. Depression, social phobia, BDD, eating disorders were the four conditions most highly associated with experiences of bullying. Over 95% of participants reported that they believed depression was associated with bullying. Conversely, over 90% of participants suggested health anxiety was not a condition associated with bullying. Only 34% of participants believed there may be a link between bullying and OCD, but this figure increased to 54% when the researchers controlled for those therapists who had limited knowledge or experience treating the disorder. Therapists clearly vary in their knowledge of such links (or lack of them) based on some mixture of training, experience and understanding of research.

In terms of qualitative data, thematic analysis generated several themes. Most notably, the way in which experiences of bullying can impact a victim's life achievements. Therapists suggested that being bullied can affect a person's ability to form relationships as well as negatively affecting an individual's achievements or attainments in school or throughout their working life. Therapist's also discussed the impact bullying can have on a person's sense of self. According to the therapists in the study it can cause the individual to struggle with their identity and reappraise their sense of self. Ultimately, bullying can lead to an individual developing mental health difficulties, resulting in the diagnosis of a psychological disorder.

Finally, the third study (chapter 6) explored the theory with a specific clinical sample. Using 4 groups, participants were divided based on if they had a diagnosis of OCD (yes/no) and if they had experienced bullying (yes/no). The researchers aimed to investigate whether there were differences in symptomology if the individual had been bullied, and if there were particular types of bullying that were associated with the development of OCD. Unfortunately, due to recruitment difficulties and sample distribution issues, the researchers were unable to follow the analysis plan and were limited by the quantitative testing available to them given the dataset. A major and unexpected finding was that significantly more individuals with OCD report bullying, but that the broad-brush experiences of bullying do not differ between the groups.

Fortunately, the study did produce considerable qualitative data. Thematic analysis developed some interesting findings, with 2 overarching themes in particular. Participants reported ways in which bullying impacted on others; most individuals discussed friendships and how in some cases their friends protected them from the bully, which is in direct contrast with the majority of participants who reported that their friends often were the bullies. Similar to the second study, the

individuals in this sample also discussed how bullying can affect their sense of self, trust, and the ability to form relationships. Clearly these results need to be replicated in more representative samples in order to be more confident of them.

All three studies yielded findings consistent with the idea that experiences of bullying can influence the development of, or cause an individual to become more susceptible to psychological disorders. The first and third studies support the theory that bullying may indeed be related of OCD and the fears of MC.

The studies did investigate the role of degradation in bullying, and the affect it has on MC. The researchers could have possibly incorporated questions relating to both degradation and humiliation in the Bullying Experiences questionnaire. There was a question asking where the bullying occurred, with the assumption that if the attacks occurred in public, the victims are more likely to feel degraded and humiliated. However, most participants reported that bullying was both public and private so the researchers could not pursue this theory. A questionnaire on betrayal was included in the third study but due to the sample distribution, the researchers were unable to analyse the results. Both degradation and betrayal were important variables in this PhD and for using bullying as a potential trigger for MC. These concepts must be revisited in future research.

These three studies focussed on the victims of bullying. The first and third study recruited individuals who had experienced bullying, comparing scores of questionnaires, and therapists offered their attitudes and opinions in relation to how bullying could influence mental health difficulties. The effects of bullying others and how the perpetrator could potentially develop MC was beyond the scope of the PhD, but worth investigating at a later date.

As with the dirty kiss studies (Fairbrother and Rachman 2004, Fairbrother, Newth et al. 2005), bullying can have an element of physicality to it. The dirty kiss paradigm revolved around an imagined, physical kiss. Participants who reported bullying often reported a physical element, being pushed for example. Not one participant indicated purely psychological bullying. This raises the question, can MC be triggered without physical contact? Clearly, after a violation, MC can be provoked by memories, smells, etc, but it is proving difficult to distinguish between CC and MC.

Impact on the theory of Mental Contamination

The research in this PhD programme is consistent with the notion that experiences of bullying influence the development of fears of MC. The question is, what is the mechanism by which it operates? The researcher attempted to explore the idea that feelings of betrayal are associated with MC to some degree. Bullying can provoke feelings of betrayal. In both study one and three the researchers developed themes relating to friendship. A considerable number of participants reported being bullied by a friend, best friend, or someone in the friendship group. We trust our friends and expect support from them, so it is plausible to suggest that these

participants felt betrayed, supporting hypotheses and previous research. Unfortunately, the researchers were unable to use the data from the betrayal questionnaire due to recruitment issues, but this may have further supported the betrayal hypothesis.

The way in which our parent react can also influence feelings of betrayal. As the primary care givers, we expect parents to provide support and security. If a parent does not provide these basic needs and seem to agree with the bully in these situations, the victims may develop feelings of betrayal. A number of participants discussed parents who were aggressive, or bullies themselves, which could also explain why the first and third studies support the link between bullying and MC.

The researchers also aimed to explore the idea of degradation in the theory of MC, to some degree. Without putting the word 'degradation', 'humiliation', or 'embarrassment' in the heads of participants, it is a difficult topic to explore. The Bullying Experiences questionnaire included the question, "was the bullying private, or did it occur in front of others?" as public bullying is most likely to provoke feelings of degradation. Nearly every participant reported that bullying was both public and private. Moreover, very few individuals actually used words relating to degradation, so this programme was unable to support the idea that degradation may be related to MC.

In the programme, the author proposed the notion that MC may develop if an individual has unstable views of their 'self'. Results from all three studies are consistent with this idea. The researchers developed a self theme in the second study, and therapists discussed topics including self-esteem, self-perceptions, self-worth, self-criticism, amongst other things. Self was a key theme in this study, suggesting that they believe bullying can affect a person's sense of self. This could be another explanation as to why bullying may be related to MC.

Studies one and three were similar so the support produced for the link between self and MC was much the same. In the Bullying Experiences questionnaire, a number of participants indicated that they believed their experiences of bullying affected their levels of self-esteem, self-worth, and a few suggested that they deserved the bullying. Not only does this support the idea that MC could be related to an individual's sense of self, it also indicates social rank could be involved.

This idea that a person's sense of self could be connected to MC could help to understand a few different areas within the theory of MC. Firstly, the notion can be applied to both the victim and the perpetrator of a traumatic incident. Whether it is experiencing bullying at school, sexual assault, other forms of violation, the victim is degraded, made to feel worthless, and therefore develops feelings of internal dirtiness – after all, both MC and self-perceptions are internal experiences. However, the perpetrator could be in a position where they have to perform negative acts, may be influenced by drugs or alcohol, or just the heat of the

moment, but their behaviour may conflict with their sense of self, and develop MC as a result.

Rachman introduced the "self-contamination" aspect within the theory of MC (Rachman 2004). By definition, this area revolves around the self. Although this area of MC severely lacks empirical investigation, all three of the studies in this programme support the notion that the self can be involved in developing feelings of internal dirtiness. Similarly, MC is also associated with post-traumatic stress disorder (PTSD), a condition often related to war veterans, or victims of sexual assault. This 'self' component could be the explanation as to why some individuals diagnosed with PTSD indulge in compulsive washing.

That being said, not every victim of bullying develops MC. Not every individual who receives criticisms internalises the negativity, allowing the situation to affect their sense of self. So why do some individuals develop MC? It could be a vulnerability, possibly related to self-perceptions. These individuals could be more anxious and therefore more susceptible to MC and OCD. Or maybe they have a more obsessive personality. Clearly this PhD has not answered every question relating to MC and completed the theory. It has however, connected feelings of internal dirtiness to a regular traumatic experience in bullying. Considerably more research is required.

Future research

MC is an extremely broad concept that requires more empirical investigation in every area. The obvious idea would be to repeat study three and get the numbers required to perform the full data analysis. The study could also benefit from adding another group; as well as an OCD group and a control, the researcher suggests recruiting individuals with PTSD and possibly anxiety or depression. This would enable a comparison of different disorders to investigate whether experiences of bullying differ, as well as the reactions of the victims. The group of participants with PTSD would allow the researcher to explore differences in MC. There could be differences in symptomology or neutralising behaviour if associated with OCD compared to PTSD.

A detailed investigation could be designed to explore support networks. Although participants in the first and third studies mentioned aggressive or abusive parents, the researcher could not produce any form of conclusions as the data was not detailed enough. This study could also look in more detail at the role of siblings, teachers and friends. This would almost certainly generate knowledge about how betrayal fits within the theory of MC.

Knowledge could also be gained by investigating the feelings individuals experience whilst they are being bullied. Researchers believe degradation and humiliation are involved in MC, and this form of investigation could provide support for this idea. It could also identify other feelings or emotions which are equally as important in fears of contamination.

Finally, the perpetrator. All three studies on the consequences of being bullied, how this may affect mental health difficulties, and how this relates to MC. However, there are at least two individuals involved in the act of bullying, and they are equally important. It would be interesting to look at those who have bullied and the feelings and emotions that they experience. It could provide information as to why they start to bully others, and knowledge about self-contamination.

Conclusion

A key issue in considering psychological processes in problems such as OCD is the distinction between problem (or disorder) *relevant* processes or factors as opposed to problem (or disorder) *specific* processes or factors. For example, perception of threat is relevant across all types of anxiety related problems; however, the focus of misinterpretation is frequently specific to particular problems. The researcher started with the view, drawn from existing literature, that bullying was likely to be relevant to OCD and other problems, and that it may be specific to MC. The results overall are consistent with this notion, subject to replication and the inclusion of appropriate comparison groups in future studies. The relationship between bullying and possible mediating factors is also important in terms of future research; problem specific factors may include responsibility perceptions, betrayal sensitivity, self-perceptions and feeling tainted.

It has long been known that being bullied is likely to have adverse psychological effects. However, historically and even more recently attitudes towards bullying has been that it could be "character building" (Sunday Morning Herald) (2007). Despite such attitudes, the evidence is clear, both from the present study and in general; being bullied massively increases a person's likelihood of immediate and later adverse effects. The present research reinforces the notion that interventions for those bullied, preferably at the earliest possible stage, are highly desirable. Secondary prevention (that is, interventions in those who have experienced bullying but not yet developed serious psychological sequelae) would seem an obvious target. In terms of those who have developed problems such as OCD, the present findings suggest that attention to obsessional thinking and MC in those who have been bullied would be key. However, further research on both moderating and mediating factors is needed to better manage both secondary and tertiary prevention of this kind.

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Appendix 1 - Study 1Consent Form

The Relationship Between Experiences of Bullying and Mental Health

PARTICIPANT CONSENT FORM

Once you have read the Participant Information Form and if you decide that you would like to participate in the study, please read the statements below and **initial** the boxes.

Title of Research Project: *The Relationship Between Experiences of Bullying and Mental Health*
Name of Researchers: *Chris Firmin, Dr Claire Lomax and Professor Paul Salkovskis*

	Please initial box
1. I have read and understood the participant information form for this study	
2. I understand that my participation is entirely voluntary and that I am free to withdraw from the study at any time and without having to give a reason and without my medical care or legal rights being affected.	
3. I give permission for the information I provide to be stored securely at the University of Bath for the duration of 10 years after the study is completed.	
4. I agree to the study reporting the information that I provide and understand that all data written or otherwise will be made anonymous.	
5. I consent to the current researchers retaining my details for potential involvement in future research.	
6. I understand that to evaluate research quality, data collected during the study may be looked at by individuals from The University of Bath. Such monitoring would only be carried out by individuals who have a duty of confidentiality. I give permission for these individuals to have access to my data in the unlikely event that this is required.	
7. I agree to take part in this study.	

Name of Participant (Print)	Signature of Participant	Date
_____	_____	_____
Name of Researcher (Print)	Signature of Researcher	Date
_____	_____	_____

Appendix 2 - Study 1 Demographics form

The Relationship Between Experiences of Bullying and Mental Health

DEMOGRAPHIC INFORMATION FORM

Thank you so much for deciding to take part in my research. Following this page there are 8 questionnaires all measuring different aspects of bullying and mental health. I need you to complete all 8 surveys, answering every question.

Below is a set of questions about you. The information you provide may be used during data analysis, for example I may decide to investigate gender differences. I would like to remind you that all details you give here, and in the 8 questionnaires will be confidential, and will only be viewed by the researchers involved in the current study

Demographic Information

Full name: _____

Age: _____

Sex: _____

Marital Status: Married ☐ Single ☐ Long-term Relationship ☐ Widowed ☐

Do you cohabit with your partner? Yes ☐ No ☐

Nationality: _____

Occupation: _____

Highest Education Level (*eg. GCSE's, A Levels, Undergraduate, Postgraduate*):

_____

Bullied? Yes ☐ No ☐

Location of School: _____

Type of School (Private/Public): _____

If you have any questions or require further information, please contact me at:

By email: cjf30@bath.ac.uk
By phone: 01225 519512

If you have a concern about any aspect of this study or would like to contact my supervisors for any other reason, their details are below:
Dr Claire Lomax via email at: c.lomax@bath.ac.uk
Professor Paul Salkovskis via email at: pms33@bath.ac.uk

Thank you very much for your time.

Appendix 3 - Bullying Experiences Questionnaire

Bullying Experiences

This questionnaire aims to explore your experiences of bullying, your feelings whilst it was happening, its impact on your life, and your general views on bullying. By bullying we mean *"a physical, verbal or psychological attack or intimidation which causes fear, distress or harm to the victim, with more powerful person(s) oppressing a less powerful one".*

Please tick the following boxes that you have experienced. Multiple boxes may be ticked.

Physical:

- ☐ Being physically struck (*eg. Being kicked, punched, hit with hard objects*)
- ☐ Being struck by substances (*eg. Spitting, mud, ink, other dirty things thrown at you*)
- ☐ Had belongings taken from you
- ☐ Being pushed
- ☐ Other

Please specify

How old were you when this happened for the first time?_____

How often did this happen?

- ☐ Once a day
- ☐ Once a week
- ☐ Three times a week
- ☐ Monthly

Additional comments. . . .

How long did this last for?

- ☐ A day
- ☐ A week
- ☐ A Month
- ☐ A year
- ☐ Multiple years *(please specify)*_____

How many bullies were there?_____

Who Bullied you?

- ☐ A person(s) of the same age as you

- [ ] A younger person(s)
- [ ] An older person(s)

Additional comments….

Had any of the bullies been your friend?

- [ ] Yes
- [ ] No

Please specify

Verbal:

- [ ] Appearance-related name calling
- [ ] People you associate with (*eg. Friends, family*)
- [ ] Things you do
- [ ] Sporting ability
- [ ] School ability
- [ ] Social ability

Please specify

How old were you when this happened for the first time?_____

How often did this happen?

- [ ] Once a day
- [ ] Once a week
- [ ] Three times a week
- [ ] Monthly

Additional comments….

How long did this last for?

- ☐ A day
- ☐ A week
- ☐ A Month
- ☐ A year
- ☐ Multiple years *(please specify)* _____

How many bullies were there?_____

Who Bullied you?

- ☐ A person(s) of the same age as you
- ☐ A younger person(s)
- ☐ An older person(s)

Additional comments….

Had any of the bullies been your friend?

- ☐ Yes
- ☐ No

Please specify

Psychological:

- ☐ Rumours started about you
- ☐ Ignored
- ☐ Friends turned against you

☐ Other

Please specify

How old were you when this happened for the first time?_____

How often did this happen?

☐ Once a day
☐ Once a week
☐ Three times a week
☐ Monthly

Additional comments….

How long did this last for?

☐ A day
☐ A week
☐ A Month
☐ A year
☐ Multiple years *(please specify)*_____

How many bullies were there?_____

Who Bullied you?

☐ A person(s) of the same age as you
☐ A younger person(s)
☐ An older person(s)

Additional comments….

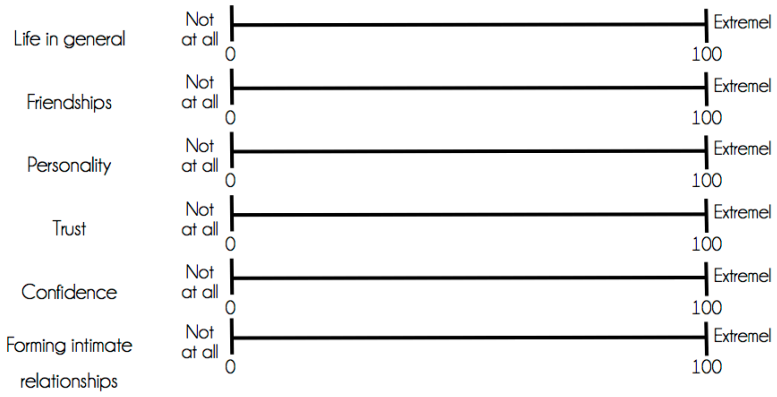
Had any of the bullies been your friend?

☐ Yes
☐ No

Please specify

General:

From a scale of 0-100 how much has your experiences of bullying affected:



Additional comments. . . .

Who did you inform that you were being bullied?

- ☐ Nobody
- ☐ Parent
- ☐ Teacher
- ☐ Friend

Please specify

If your parents knew, how did they react?

- ☐ Supportive and tried to help

- ☐ Supportive but didn't try and help
- ☐ Not particularly supportive
- ☐ Didn't take it seriously
- ☐ Critical of me because of the bully
- ☐ Critical of me because of the bully and seemed to agree

Additional comments. . . .

If you didn't inform your parents, why not?

Please specify

Do you think your parents were aware even if you did not tell them?

Please specify

If your friends knew, how did they react?

- ☐ Supportive
- ☐ Joined in with the bullying
- ☐ Didn't do anything

Additional comments. . . .

Was the bullying private, or did it occur in front of others?

Please specify

How did you react to the bullying?

Please specify

Did you ever believe the bully's comments?

Please specify

Why do you believe you were a target for bullying?

Please specify

Since the age of 18 years have you been bullied?

Please specify

Thank you for completing the questionnaire! All your answer will remain confidential. If you have any questions or require further information, please do not hesitate to contact me, Chris Firmin, on cjf30@bath.ac.uk.

Appendix 4 - OCI

OCI

Name…… Date…….. initial/ rebaseline/ mid/ end/ follow up

The following statements refer to experiences which many people have in their everyday lives. In the column labelled DISTRESS, please **CIRCLE** the number that best describes **HOW MUCH** that experience has **DISTRESSED** or **BOTHERED YOU DURING THE PAST MONTH**. The numbers in this column refer to the following labels: 0 = Not at all 1 = A little 2 = Moderately 3 = A lot 4 = Extremely

		DISTRESS				
1.	Unpleasant thoughts come into my mind against my will and I cannot get rid of them	0	1	2	3	4
2.	I think contact with bodily secretions (perspiration, saliva, blood, urine, etc) may contaminate my clothes or somehow harm me.	0	1	2	3	4
3.	I ask people to repeat things to me several times, even though I understood them the first time.	0	1	2	3	4
4.	I wash and clean obsessively.	0	1	2	3	4
5.	I have to review mentally past events, conversations and actions to make sure that I didn't do something wrong.	0	1	2	3	4
6.	I have saved up so many things that they get in the way.	0	1	2	3	4
7.	I check things more often than necessary	0	1	2	3	4
8.	I avoid using public toilets because I am afraid of disease or contamination.	0	1	2	3	4
9.	I repeatedly check doors, windows, drawers etc.	0	1	2	3	4
10.	I repeatedly check gas and water taps and light switches after turning them off.	0	1	2	3	4
11.	I collect things I don't need.	0	1	2	3	4
12.	I have thoughts of having hurt someone without knowing it.	0	1	2	3	4
13.	I have thoughts that I might want to harm myself or others.	0	1	2	3	4
14.	I get upset if objects are not arranged properly.	0	1	2	3	4
15.	I feel obliged to follow a particular order in dressing, undressing and washing myself.	0	1	2	3	4
16.	I feel compelled to count while I am doing things	0	1	2	3	4
17.	I am afraid of impulsively doing embarrassing or harmful things.	0	1	2	3	4
18.	I need to pray to cancel bad thoughts or feelings.	0	1	2	3	4
19.	I keep on checking forms or other things I have written.	0	1	2	3	4
20.	I get upset at the sight of knives, scissors and other sharp objects in case I lose control with them.	0	1	2	3	4
21.	I am excessively concerned about cleanliness.	0	1	2	3	4
22.	I find it difficult to touch an object when I know it has been touched by strangers or certain people.	0	1	2	3	4
23.	I need things to be arranged in a particular order	0	1	2	3	4

		DISTRESS				
24.	I get behind in my work because I repeat things over and over again.	0	1	2	3	4
25.	I feel I have to repeat certain numbers.	0	1	2	3	4
26.	After doing something carefully, I still have the impression I have not finished it.	0	1	2	3	4
27.	I find it difficult to touch garbage or dirty things.	0	1	2	3	4
28.	I find it difficult to control my own thoughts.	0	1	2	3	4
29.	I have to do things over and over again until it feels right.	0	1	2	3	4
30.	I am upset by unpleasant thoughts that come into my mind against my will.	0	1	2	3	4
31.	Before going to sleep I have to do certain things in a certain way.	0	1	2	3	4
32.	I go back to places to make sure that I have not harmed anyone.	0	1	2	3	4
33.	I frequently get nasty thoughts and have difficulty in getting rid of them.	0	1	2	3	4
34.	I avoid throwing things away because I am afraid I might need them later.	0	1	2	3	4
35.	I get upset if others change the way I have arranged my things.	0	1	2	3	4
36.	I feel that I must repeat certain words or phrases in my mind in order to wipe out bad thoughts, feelings or actions.	0	1	2	3	4
37.	After I have done things, I have persistent doubts about whether I really did them.	0	1	2	3	4
38.	I sometimes have to wash or clean myself simply because I feel contaminated.	0	1	2	3	4
39.	I feel that there are good and bad numbers.	0	1	2	3	4
40.	I repeatedly check anything which might cause a fire.	0	1	2	3	4
41.	Even when I do something very carefully I feel that it is not quite right.	0	1	2	3	4
42.	I wash my hands more often or longer than necessary.	0	1	2	3	4

For therapist use:

Washing	
Checking	
Doubting	
Ordering	
Obsessions	
Hoarding	
Neutralising	
Total	

Appendix 5 - VOCI-MC

VOCI - MC Scale

Please rate the extent to which you agree with the following statements?	**Not at all**	**A little**	**Some**	**Much**	**Very much**
1. Often I look clean but feel dirty.	0	1	2	3	4
2. Having an unpleasant image or memory can make me feel dirty inside.	0	1	2	3	4
3. Often I cannot get clean no matter how thoroughly I wash myself.	0	1	2	3	4
4. If someone says something nasty to me it can make me feel dirty.	0	1	2	3	4
5. Certain people make me feel dirty or contaminated even without any direct contact.	0	1	2	3	4
6. I often feel dirty under my skin.	0	1	2	3	4
7. Some people look clean, but feel dirty.	0	1	2	3	4
8. I often feel dirty or contaminated even though I haven't touched anything dirty.	0	1	2	3	4
9. Often when I feel dirty or contaminated, I also feel guilty or ashamed.	0	1	2	3	4
10. I often experience unwanted and upsetting thoughts about dirtiness.	0	1	2	3	4
11. Some objects look clean, but feel dirty.	0	1	2	3	4
12. I often feel dirty or contaminated without knowing why.	0	1	2	3	4
13. Often when I feel dirty or contaminated, I also feel angry.	0	1	2	3	4
14. Unwanted and repugnant thoughts often make me feel contaminated or dirty.	0	1	2	3	4
15. Standing close to certain people makes me feel dirty and/or contaminated.	0	1	2	3	4
16. I often feel dirty inside my body.	0	1	2	3	4
17. If I experience certain unwanted repugnant thoughts, I need to wash myself.	0	1	2	3	4
18. Certain people or places that make me feel dirty or contaminated leave everyone else completely unaffected.	0	1	2	3	4
19. The possibility that my head will be filled with worries about contamination makes me very anxious.	0	1	2	3	4
20. I often feel the need to cleanse my mind.	0	1	2	3	4

Appendix 6 - S-CTN

S-CTN

Do you *disagree* or *agree* with the following statements?	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1. It scares me when my hands feel sticky.	0	1	2	3	4
2. When there is something wrong with my stomach, I worry that I might be seriously ill.	0	1	2	3	4
3. It scares me when I feel dirty *inside* my body.	0	1	2	3	4
4. I can always smell if there is something rotting.	0	1	2	3	4
5. It is always important for me to wash myself absolutely clean.	0	1	2	3	4
6. If I cannot get rid of worries about contamination, I am nervous that I might be going crazy.	0	1	2	3	4
7. Touching clothing that belongs to someone I strongly dislike would make me feel nervous.	0	1	2	3	4
8. Eating fruit or vegetables that are not organic makes me feel tense and nervous.	0	1	2	3	4
9. I keep well away from people who look ill.	0	1	2	3	4
10. For me, unpleasant smells are extremely nauseating.	0	1	2	3	4
11. It scares me if I feel dirty *under* my skin.	0	1	2	3	4
12. It is important for me to keep well away from weird or mentally unstable people.	0	1	2	3	4
13. It scares me when my skin feels all prickly.	0	1	2	3	4
14. If I feel very contaminated, I get nervous that I might become mentally unstable.	0	1	2	3	4

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
15. For me it is much safer to eat fruit that has a removable skin.	0	1	2	3	4
16. I pick up illnesses far more easily than do other people.	0	1	2	3	4
17. Other people can tell if I feel contaminated.	0	1	2	3	4
18. If a weird or mentally unstable person comes close to me, I get very nervous.	0	1	2	3	4
19. If food is not completely fresh, I can tell right away.	0	1	2	3	4
20. I am extremely sensitive to tastes.	0	1	2	3	4
21. It scares me if I feel contaminated.	0	1	2	3	4
22. I worry about picking up some illness whenever I visit a hospital.	0	1	2	3	4
23. Unusual sensations on my skin make me very nervous.	0	1	2	3	4
24. I am extremely sensitive to smells.	0	1	2	3	4

Appendix 7 - CTN - TAF

CTN – TAF Scale

Do you *disagree* or *agree* with the following statements?	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1. If I have a thought about a friend/relative getting ill, it increases the risk that he/she will actually get ill.	0	1	2	3	4
2. If I get an image of myself being contaminated, it will make me feel contaminated.	0	1	2	3	4
3. If I have a thought of a friend/relative becoming contaminated, it increases the risk of them getting contaminated.	0	1	2	3	4
4. If I have a thought about myself getting ill, it increases the risk that I will get ill.	0	1	2	3	4
5. If I have a thought about getting contaminated, it increases the risk of actually becoming contaminated.	0	1	2	3	4
6. If I have a thought that I might pass on contamination to a child, it increases the risk that the child will become contaminated.	0	1	2	3	4
7. Having a thought that I might pass contamination on to someone else is almost as bad as actually doing it.	0	1	2	3	4
8. If I get an image of a friend/relative being contaminated, it will increase the risk that he/she will actually become contaminated.	0	1	2	3	4
9. If I have a thought that I might pass on contamination to a child, that is almost as bad as actually passing it on.	0	1	2	3	4

Appendix 8 - GAD-7

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Appendix 9 - PHQ-9

Name _____ Date _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

(For office coding: Total Score _____ = _____ + _____ + _____)

If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Appendix 10 - Study 2 Consent Form

An investigation to explore the attitudes of therapists towards bullying and their effect on mental health problems.

PARTICIPANT CONSENT FORM

If you would like to participate in the study, please read the statements below and **initial** the boxes.

Name of Researchers: *Chris Firmin, Dr Claire Lomax and Professor Paul Salkovskis*

		Please initial box
1.	I have read and understood the participant information form for this study	☐
2.	I understand that my participation is entirely voluntary and that I am free to withdraw from the study at any time and without having to give a reason and without my medical care or legal rights being affected.	☐
3.	I give permission for the information I provide to be stored securely at the University of Bath for the duration of 10 years after the study is completed.	☐
4.	I agree to the study reporting the information that I provide and understand that all data written or otherwise will be made anonymous.	☐
5.	I consent to the current researchers retaining my details for potential involvement in future research.	☐
6.	I understand that to evaluate research quality, data collected during the study may be looked at by individuals from The University of Bath. Such monitoring would only be carried out by individuals who have a duty of confidentiality. I give permission for these individuals to have access to my data in the unlikely event that this is required.	☐
7.	I agree to take part in this study.	☐

Name of Participant (Print)	Signature of Participant	Date
_____	_____	_____
Name of Researcher (Print)	Signature of Researcher	Date
_____	_____	_____

Appendix 11 - Study 2 Demographics Form

UNIVERSITY OF BATH

An investigation to explore the attitudes of therapists towards bullying and their effects on mental health problems.

Demographic information

I confirm that I have completed a consent form: ☐ Yes ☐ No

Please complete the following information about yourself:
Your current job title: _____
Your professional background (e.g. clinical psychology):_____
Your gender: ☐ Female ☐ Male
Your age: ____
Number of years in practice as a therapist post qualification (if still in training, please state this):_____
Specialist area: _____
Which clinical or therapeutic model do you use most in your practice? Please choose only one:

- ☐ Behaviour therapy
- ☐ Cognitive therapy
- ☐ Cognitive behaviour therapy
- ☐ Counselling
- ☐ Eclectic
- ☐ Integrated
- ☐ Psychodynamic
- ☐ Psychiatric
- ☐ Systemic
- ☐ Other - please state: _____

How many clients with each of the following disorders as their main problem have you treated in the last 12 months? Please circle a category for each problem.

Body Dysmorphic Disorder	0	1 - 5	6 - 10	11 - 15	16 - 20	20 +
Depression	0	1 - 5	6 - 10	11 - 15	16 - 20	20 +
Eating Disorders	0	1 - 5	6 - 10	11 - 15	16 - 20	20 +
Generalised Anxiety Disorder	0	1 - 5	6 - 10	11 - 15	16 - 20	20 +
Health Anxiety (Hypochondriasis)	0	1 - 5	6 - 10	11 - 15	16 - 20	20 +
Obsessive Compulsive Disorder	0	1 - 5	6 - 10	11 - 15	16 - 20	20 +
Panic Disorder	0	1 - 5	6 - 10	11 - 15	16 - 20	20 +
Personality Disorders	0	1 - 5	6 - 10	11 - 15	16 - 20	20 +
Post-Traumatic Stress Disorder	0	1 - 5	6 - 10	11 - 15	16 - 20	20 +
Psychosis	0	1 - 5	6 - 10	11 - 15	16 - 20	20 +
Social Phobia	0	1 - 5	6 - 10	11 - 15	16 - 20	20 +
Specific Phobia	0	1 - 5	6 - 10	11 - 15	16 - 20	20 +
Substance Misuse	0	1 - 5	6 - 10	11 - 15	16 - 20	20 +
Other Clinical Problems	0	1 - 5	6 - 10	11 - 15	16 - 20	20 +

Please indicate, by ticking the boxes, which disorders you believe bullying is most likely to effect:

- ☐ Body Dysmorphic Disorder
- ☐ Depression
- ☐ Eating Disorders
- ☐ Generalized Anxiety Disorders
- ☐ Health Anxiety (Hypochondriasis)
- ☐ Obsessive Compulsive Disorder
- ☐ Panic Disorder
- ☐ Personality Disorders
- ☐ Post-Traumatic Stress Disorder
- ☐ Psychosis
- ☐ Social Phobia
- ☐ Specific Phobia
- ☐ Substance Misuse
- ☐ Other Clinical Problems

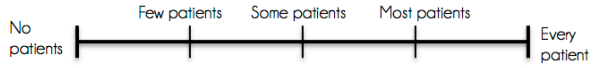
Appendix 12 - Attitudes towards Bullying Scale

Attitudes Towards Bullying

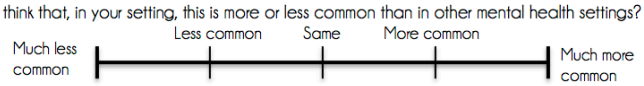
UNIVERSITY OF BATH

Before completing the rest of this survey, please can you briefly share any thoughts you might have about the relationship between bullying and mental health:

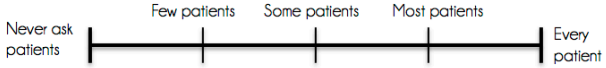
How many of your patients do you think have experienced bullying at some point during their lifetime?



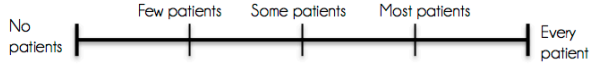
Do you think that, in your setting, this is more or less common than in other mental health settings?



How frequently do you ask patients about experiences of bullying?



How frequently do patients spontaneously report experiences of bullying?



Do you think that bullying is a common experience in patients with mental health problems?
Rate in terms of general population eg as common as *others same age and background*

Please answer the following questions keeping in mind those patients who you have seen and told you that they had experienced bullying:

What effects do you think bullying has on an individual's mental health?

What effect do you think bullying has on an individual's education?

How do you think bullying effects an individual's adult life?

How do you think victims of bullying perceive its effects on their mental health?

How do you think victims perceive the effects of bullying on their adult life?

Do you think the victims tend to believe that the bully's verbal attacks are true?

How do you think victims perceive the effects of bullying on their education?

Do you think bullying effects the victim's sense of self?

In terms of your clinical practise:

When it is present, do you incorporate bullying and its effects in your formulation?

Do you target it?

Do you think the experience of bullying effects the patients' ability to form a therapist relationship?

Appendix 13 - Study 3 Consent Form

An investigation into potential factors that may influence experiences of OCD

PARTICIPANT CONSENT FORM

Once you have read the Participant Information Form and if you decide that you would like to participate in the study, please read the statements below and **initial** the boxes.

Name of Researchers: *Chris Firmin, Dr Claire Lomax and Professor Paul Salkovskis*

	Please initial box
1. I have read and understood the participant information form for this study	
2. I understand that my participation is entirely voluntary and that I am free to withdraw from the study at any time and without having to give a reason and without my medical care or legal rights being affected.	
3. I give permission for the information I provide to be stored securely at the University of Bath for the duration of 10 years after the study is completed.	
4. I agree to the study reporting the information that I provide and understand that all data written or otherwise will be made anonymous.	
5. I consent to the current researchers retaining my details for potential involvement in future research.	
6. I understand that to evaluate research quality, data collected during the study may be looked at by individuals from The University of Bath. Such monitoring would only be carried out by individuals who have a duty of confidentiality. I give permission for these individuals to have access to my data in the unlikely event that this is required.	
7. I agree to take part in this study.	

Name of Participant (Print) _____ Signature of Participant _____ Date _____

Appendix 14 - Study 3 Demographics Form

UNIVERSITY OF BATH

An investigation into potential factors
that may influence the experiences of OCD

DEMOGRAPHIC INFORMATION FORM

Thank you so much for deciding to take part in my research. Below is a set of questions about you. The information you provide may be used during data analysis, for example I may decide to investigate gender differences. I would like to remind you that all details you give here, and in the following questionnaires will be confidential, and will only be viewed by the researchers involved in the current study

Demographic Information

Full name: _____

Age: _____

Sex: _____

Marital Status: Married ☐ Single ☐ Long-term Relationship ☐ Widowed ☐

Do you cohabit with your partner? Yes ☐ No ☐

Nationality: _____

Occupation: _____

Highest Education Level (*eg. GCSE's, A Levels, Undergraduate, Postgraduate*):

_____

Bullied? Yes ☐ No ☐

Location of School: _____

Type of School (Private/Public): _____

Have you ever been diagnosed as suffering from either a psychotic disorder or substance dependence? Yes ☐ No ☐

If you have any questions or require further information, please contact me at:

By email: cjf30@bath.ac.uk
By phone: 01225 519512

If you have a concern about any aspect of this study or would like to contact my supervisors for any other reason, their details are below:
Professor Paul Salkovskis via email at: pms33@bath.ac.uk

Thank you very much for your time.

Appendix 15 - Bullying and Guilt Questionnaire

Questionnaire on bullying and guilt

Individuals who have experienced bullying are picked on by the people who bully them for many different reasons, and may have had to endure different types of abuse. As a result, people react very differently and may or may not suffer from various problems at the time of the bullying and later in life. For example, some victims of bullying actually report feelings of guilt as a result of the abuse.

The purpose of this questionnaire is to help us learn more about the ways people react to bullying. We will be very grateful if you could consider answering the questions below.

Thank you ever so much for your time and effort filling in this questionnaire.

Part A

Please could you take a few moments to think about ***what happened when you were bullied***.

All the statements below refer to reactions that people may have when they are bullied. Please consider each statement and **circle** the answer that best describes how you feel.

1. I could have prevented myself from being bullied

Extremely true Very true True Slightly true Not at all true

2. I am still distressed by my experiences of bullying.

Always true Very true True Slightly true Not at all true

3. I had some feelings that I should not have had.

Always true Very true True Slightly true Not at all true

4. My reactions to the bully were completely appropriate.

Extremely true Very true True Slightly true Not at all true

5. I was responsible for being bullied.

Extremely true Very true True Slightly true Not at all true

6. My memories of being bullied cause me emotional pain.

Always true Very true True Slightly true Not at all true

7. I feel sorrow or grief about what happened to me.

Always true Very true True Slightly true Not at all true

8. My reactions to bullying were inconsistent with my beliefs.

Extremely true Very true True Slightly true Not at all true

9. I believe THEN that I deserved to be bullied.

Extremely true Very true True Slightly true Not at all true

10. I believe NOW that I deserved to be bullied.

Extremely true Very true True Slightly true Not at all true

11. I experience intense guilt about my experiences of bullying.

Always true Very true True Slightly true Not at all true

12. I experience severe emotional distress when I think about my experiences of bullying.

Always true | Very true | True | Slightly true | Not at all true

13. When I was bullied, I reacted in the best way I reasonably could have. .

Extremely true | Very true | True | Slightly true | Not at all true

14. Currently, how often do you have memories of the bullying you experienced?

Never | Seldom | Occasionally | Often | Always

15. I blame myself for being bullied.

Extremely true | Very true | True | Slightly true | Not at all true

16. When I think about the bullying I experienced, I blame myself for something I did, thought, or felt.

Extremely true | Very true | True | Slightly true | Not at all true

17. I hold myself responsible for what happened when I was bullied.

Extremely true | Very true | True | Slightly true | Not at all true

18. I violated personal standards of right and wrong in terms of my reactions to being bullied.

Extremely true | Very true | True | Slightly true | Not at all true

19. I regret not doing certain things in response to being bullied.

Extremely true | Very true | True | Slightly true | Not at all true

20. I didn't do anything wrong in terms of my reactions to being bullied.

Extremely true | Very true | True | Slightly true | Not at all true

21. Currently, how often do you have memories of the bullying you experienced?

Always true | Very true | True | Slightly true | Not at all true

Part B

In this section, we would like you to think about any memories you have about being bullied. **Please rate how those memories usually make your feel when they occur nowadays**

When I recall being bullied, I feel:

Anxious	0	10	20	30	40	50	60	70	80	90	100
	Not at all										Extremely
Sad	0	10	20	30	40	50	60	70	80	90	100
	Not at all										Extremely
Angry	0	10	20	30	40	50	60	70	80	90	100
	Not at all										Extremely
Guilty	0	10	20	30	40	50	60	70	80	90	100
	Not at all										Extremely

Dirty	0 Not at all	10	20	30	40	50	60	70	80	90	100 Extremely
Betrayed	0 Not at all	10	20	30	40	50	60	70	80	90	100 Extremely
Degraded	0 Not at all	10	20	30	40	50	60	70	80	90	100 Extremely
Ashamed	0 Not at all	10	20	30	40	50	60	70	80	90	100 Extremely
Violated	0 Not at all	10	20	30	40	50	60	70	80	90	100 Extremely
Contaminated	0 Not at all	10	20	30	40	50	60	70	80	90	100 Extremely
Defeated	0 Not at all	10	20	30	40	50	60	70	80	90	100 Extremely

Thank you so much for the time and effort that you have put into completing this questionnaire.

Appendix 16 - SCID

Please could you spend a few minutes thinking about your OCD in its early stages, and if you are happy, could you answer the following questions.

1. How old were you when what you now know as your obsessions or compulsions first started? ..... years old

2. How old were you when your OCD first started to interfere significantly with your life? ..... years old

3. Have you ever asked for help for what you now know as your OCD from your GP or from a mental health service within the NHS? Yes No

   If yes, who did you *first* ask for help from?
   My GP Yes No
   Improving Access to Psychological Therapies (IAPT) service Yes No
   Another mental health service within the NHS Yes No

   If yes, how old were you when you *first* sought help for what you now know as your OCD? ..... years old

4. Did you know that your problem was OCD before you first sought help? Yes No

   If yes, how old were you when you first found out that your problem was OCD? ..... years old

5. How old were you when your GP or the mental health service first told you that you had OCD? ..... years old

6. How old were you when you were first offered treatment for your OCD that had been recognised / diagnosed as such? ..... years old

Appendix 17 - RIQ

Name..... Date.....

RIQ

We are interested in your reaction to intrusive thoughts that you have had in the **last 2 weeks**.
Intrusive thoughts are thoughts that suddenly enter your mind, may interrupt what you are thinking or doing and tend to recur on separate occasions. They may occur in the form of words, mental image, or an impulse (a sudden urge to carry out some action). We are interested in those intrusive thoughts that are unacceptable. Research has shown that most people experience or have experienced such thoughts which they find unacceptable in some way, at some time in their lives to a greater or lesser degree, so there is nothing unusual about this.

Some examples of unpleasant intrusions are:

Repeated image of attacking someone
Suddenly thinking that your hands are dirty and you may cause contamination
Suddenly thinking you might not have turned off the gas, or that you left a door unlocked
Repeated senseless images of harm coming to someone you love
Repeated urge to attack or harm somebody (even though you would never do this)

These are just a few examples of intrusions to give you some idea of what we are looking at; people vary tremendously in the type of thoughts that they have.

IMPORTANT

Think of INTRUSIONS OF THE TYPE DESCRIBED ABOVE that you have had in the last 2 weeks, and answer the following questions with these intrusions in mind. The questions do NOT relate to all thoughts but specifically to your negative intrusions.

Please write down intrusions that you have had in the last 2 weeks:

1.

2.

3

4.

5.

Appendix 18 - Beliefs

BELIEFS

Over the last two weeks. When you were bothered by these worrying intrusive thoughts, how much did you **believe** each of these ideas to be true? Rate the belief you had of these ideas when you had the intrusions, using the following scale; mark the point on the line that most accurately applies to your belief at the time of the intrusion.

B1	I did not believe this idea at all										I was completely convinced this idea was true
If I don't resist these thoughts it means I am being irresponsible	0	10	20	30	40	50	60	70	80	90	100
I could be responsible for serious harm	0	10	20	30	40	50	60	70	80	90	100
I can not take the risk of this thought coming true	0	10	20	30	40	50	60	70	80	90	100
If I don't act now then something terrible will happen and it will be my fault	0	10	20	30	40	50	60	70	80	90	100
I need to be certain something awful won't happen	0	10	20	30	40	50	60	70	80	90	100
I should not be thinking this kind of thing	0	10	20	30	40	50	60	70	80	90	100
It would be irresponsible to ignore these thoughts	0	10	20	30	40	50	60	70	80	90	100
I'll feel awful unless I do something about this thought	0	10	20	30	40	50	60	70	80	90	100
Because I've thought of bad things happening then I must act to prevent them	0	10	20	30	40	50	60	70	80	90	100
Since I've had this thought I must want it to happen	0	10	20	30	40	50	60	70	80	90	100
Now I've thought of bad things which could go wrong I have a responsibility to make sure I don't let them happen	0	10	20	30	40	50	60	70	80	90	100
Thinking this could make it happen	0	10	20	30	40	50	60	70	80	90	100
I must regain control of these thoughts	0	10	20	30	40	50	60	70	80	90	100
This could be an omen	0	10	20	30	40	50	60	70	80	90	100
It's wrong to ignore these thoughts	0	10	20	30	40	50	60	70	80	90	100
Because these thoughts come from my mind, I must want to have them	0	10	20	30	40	50	60	70	80	90	100

Appendix 19 - RAS

RAS

This questionnaire lists different attitudes or beliefs which people sometimes hold. Read each statement carefully and decide how much you agree or disagree with it.
For each of the attitudes, show your answer by putting a circle round the words which BEST DESCRIBE HOW YOU THINK. Be sure to choose only one answer for each attitude. Because people are different, there is no right answer or wrong answer to these statements.
To decide whether a given attitude is typical of your way of looking at things, simply keep in mind what you are like MOST OF THE TIME.

1. I often feel responsible for things which go wrong.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

2. If I don't act when I can foresee danger, then I am to blame for any consequences if it happens.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

3. I am too sensitive to feeling responsible for things going wrong.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

4. If I think bad things, this is as bad as doing bad things.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

5. I worry a great deal about the effects of things which I do or don't do.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

6. To me, not acting to prevent disaster is as bad as making disaster happen.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

7. If I know that harm is possible, I should always try to prevent it, however unlikely it seems.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

8. I must always think through the consequences of even the smallest actions.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

9. I often take responsibility for things which other people don't think are my fault.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

10. Everything I do can cause serious problems.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

11. I am often close to causing harm.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

12. I must protect others from harm.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

13. I should never cause even the slightest harm to others.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

14. I will be condemned for my actions.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

15. If I can have even a slight influence on things going wrong, then I must act to prevent it.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

16. To me, not acting where disaster is a slight possibility is as bad as making that disaster happen.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

17. For me, even slight carelessness is inexcusable when it might affect other people.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

18. In all kinds of daily situations, my inactivity can cause as much harm as deliberate bad intentions.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

19. Even if harm is a very unlikely possibility, I should always try to prevent it at any cost.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

20. Once I think it is possible that I have caused harm, I can't forgive myself.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

21. Many of my past actions have been intended to prevent harm to others.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

22. I have to make sure other people are protected from all of the consequences of things I do.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

23. Other people should not rely on my judgement.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

24. If I cannot be certain I am blameless, I feel that I am to blame.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

25. If I take sufficient care then I can prevent any harmful accidents.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

26. I often think that bad things will happen if I am not careful enough.

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

Appendix 20 - Disgust

Disgust Scale – Revised

DS-R Part I: Please circle true or false

1. I might be willing to try eating monkey meat, under some circumstances.

False True

2. It would bother me to see a rat run across my path in a park.

False True

3. Seeing a cockroach in someone else's house doesn't bother me.

False True

4. It bothers me to hear someone clear a throat full of mucus.

False True

5. If I see someone vomit, it makes me sick to my stomach.

False True

6. It would bother me to be in a science class, and see a human hand preserved in a jar.

False True

7. It would not upset me at all to watch a person with a glass eye take the eye out of the socket.

False True

8. It would bother me tremendously to touch a dead body.

False True

9. I would go out of my way to avoid walking through a graveyard.

False True

10. I never let any part of my body touch the toilet seat in a public washroom.

False True

11. I probably would not go to my favorite restaurant if I found out that the cook had a cold.

False True

12. Even if I was hungry, I would not drink a bowl of my favorite soup it if had been stirred with a used but thoroughly washed flyswatter.

False True

13. It would bother me to sleep in a nice hotel room if I knew that a man had died of a heart attack in that room the night before.

False True

Disgust Scale – Revised

Part II: Please rate how disgusting you would find the following experiences.

14. If you see someone put ketchup on vanilla ice cream and eat it.

Not Slightly Vey

15. You are about to drink a glass of milk when you smell that it is spoiled.

Not Slightly Vey

16. You see maggots on a piece of meat in an outdoor garbage pail.

Not Slightly Vey

17. You are walking barefoot on concrete and step on an earthworm.

Not Slightly Vey

18. While you are walking through a tunnel under a railroad track, you smell urine.

Not Slightly Vey

19. You see a man with his intestines exposed after an accident.

Not Slightly Vey

20. Your friend's pet cat dies and you have to pick up the dead body with your bare hands.

Not Slightly Vey

21. You accidentally touch the ashes of a person who has been cremated.

Not Slightly Vey

22. You take a sip of soda and realize that you drank from the glass that an acquaintance of yours had been drinking from.

Not Slightly Vey

23. You discover that a friend of yours changes underwear only once a week.

Not Slightly Vey

24. A friend offers you a piece of chocolate shaped like dog-doo.

Not Slightly Vey

25. As part of a sex education class, you are required to inflate a new lubricated condom, using your mouth.

Not Slightly Vey

Appendix 21 - Shame

Experience of Shame Scale

Everybody at times can feel embarrassed, self-conscious or ashamed. These questions are about such feelings if they have occurred **at any time in the past year**. There are no 'right' or 'wrong' answers.

Please circle the answer that applies to you for each question.

1. Have you felt ashamed of any of your personal habits?

Not at all A little Moderately Very much

2. Have you worried about what other people think of any of your personal habits?

Not at all A little Moderately Very much

3. Have you tried to cover up or conceal any of your personal habits?

Not at all A little Moderately Very much

4. Have you felt ashamed of your manner with others?

Not at all A little Moderately Very much

5. Have you worried about what other people think of your manner with others?

Not at all A little Moderately Very much

6. Have you avoided people because of your manner?

Not at all A little Moderately Very much

7. Have you felt ashamed of the sort of person you are?

Not at all A little Moderately Very much

8. Have you worried about what other people think of the sort of person you are?

Not at all A little Moderately Very much

9. Have you tried to conceal from others the sort of person you are?

Not at all A little Moderately Very much

10. Have you felt ashamed of your ability to do things?

Not at all A little Moderately Very much

11. Have you worried about what other people think of your ability to do things?

Not at all A little Moderately Very much

12. Have you avoided people because of your inability to do things?

Not at all A little Moderately Very much

13. Do you feel ashamed when you do something wrong?

Not at all A little Moderately Very much

14. Have you worried about what other people think of you when you do something wrong?

Not at all A little Moderately Very much

15. Have you tried to cover up or conceal things you felt ashamed of having done?

Not at all A little Moderately Very much

16. Have you felt ashamed when you said something stupid?

Not at all A little Moderately Very much

17. Have you worried about what other people think of you when you said something stupid?

Not at all A little Moderately Very much

18. Have you avoided contact with anyone who knew you said something stupid?

Not at all A little Moderately Very much

19. Have you felt ashamed when you failed at something which was important to you?

Not at all A little Moderately Very much

20. Have you worried about what other people think of you when you fail?

Not at all A little Moderately Very much

21. Have you avoided people who have seen you fail?

Not at all A little Moderately Very much

22. Have you felt ashamed of your body or any part of it?

Not at all A little Moderately Very much

23. Have you worried about what other people think of your appearance?

Not at all A little Moderately Very much

24. Have you avoided looking at yourself in the mirror?

Not at all A little Moderately Very much

25. Have you wanted to hide or conceal your body or any part of it?

Not at all A little Moderately Very much

Thank you for completing the questionnaire

Appendix 22 - Social Put-Downs

Sensitivity to Social Put-Downs

In certain situations people can experience many different emotions. For example, being late for a meeting may cause some people to feel anxious or irritated. Below is a list of situations that may cause experiences of anxiety, distress, anger or irritability. Would you take your time to consider each situation and rate each in terms of anxiety/distress on the left, and anger/irritation on the right.

1 = Not at all 2 = Slightly 3 = Somewhat 4 = Very 5 = Extremely

Anxiety/Distress					Situation	Anger/Irritation				
1	2	3	4	5	1. Being criticised	1	2	3	4	5
1	2	3	4	5	2. Being shown up in public	1	2	3	4	5
1	2	3	4	5	3. Being called a derogatory name (eg. ugly/stupid)	1	2	3	4	5
1	2	3	4	5	4. Being treated like a child	1	2	3	4	5
1	2	3	4	5	5. Someone pointing out your unattractive qualities	1	2	3	4	5
1	2	3	4	5	6. Being looked at with contempt	1	2	3	4	5
1	2	3	4	5	7. Someone getting the better of you	1	2	3	4	5
1	2	3	4	5	8. Having your opinions dismissed as irrelevant	1	2	3	4	5
1	2	3	4	5	9. People reacting critically to what you say	1	2	3	4	5
1	2	3	4	5	10. Being seen as inferior	1	2	3	4	5
1	2	3	4	5	11. Being told that your 'not good enough'	1	2	3	4	5
1	2	3	4	5	12. People running you down behind your back	1	2	3	4	5
1	2	3	4	5	13. Someone trying to make you look weak or stupid	1	2	3	4	5
1	2	3	4	5	14. People having a joke at your expense	1	2	3	4	5
1	2	3	4	5	15. Not being treated with respect	1	2	3	4	5
1	2	3	4	5	16. Someone picking on your faults	1	2	3	4	5
1	2	3	4	5	17. Being seen as a nuisance	1	2	3	4	5
1	2	3	4	5	18. Being told your performance is inadequate	1	2	3	4	5
1	2	3	4	5	19. Someone making fun of you in public	1	2	3	4	5
1	2	3	4	5	20. Someone making negative comments about your physical appearance	1	2	3	4	5

Appendix 23 - Betrayal

Betrayal Impact Scale

The questions below ask you to think about times when you have experienced betrayal.

Betrayal is when someone you trust does something on purpose that causes you emotional harm.

The most common forms of betrayal are given below, with an example of each kind of betrayal.

- Disloyalty — For example, if a close friend is cruel or laughs about you to others behind your back
- Infidelity — For example, if a partner has an affair with someone else
- Dishonesty or deception — For example, if a close friends lies to you about something important
- Disclosing confidential information — For example, if a close friend tells other people things you have asked them to keep secret
- Sexually inappropriate behaviour — For example, if a trusted friend makes 'a pass' at you when you are feeling vulnerable
- Failing to help you when you need help — For example, if you have been falsely accused of a crime and your friend fails to help you even though they could.

Please circle how much you agree with the statements below, when thinking about yourself and how your experiences have had an impact on you								
1	I am more sensitive to betrayals than most people	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
2	My thoughts are often preoccupied with past betrayals	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
3	My experience of betrayal has changed the way I think about the world in general	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
4	I know that I have to rely on myself in a crisis because other people will let me down	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
5	My experience of betrayal has left me less able to cope with the stresses of life	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
6	When thoughts or memories of past betrayals come to mind, I turn then over and over in my head	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
7	My experience of betrayal has changed how I think about myself	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
8	When a past betrayal comes to mind, I immediately try to distract myself	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
9	I am careful about getting close to people for fear they will let me down	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree

10	When I think about my experiences of betrayal, I still feel shocked that this happened to me	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
11	I worry more than other people about how likely it is that people will betray my trust	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
12	Thoughts or memories of past betrayals often come to my mind out of nowhere	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
13	When I am reminded of past betrayals I feel the urge to do something in response	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
14	It's best not to rely on others as you never know when they're going to let you down	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
15	My experience of past betrayals interferes with my ability to form close relationships	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
16	I avoid reminders of past betrayals	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
17	Images or pictures of past betrayals often come to my mind out of nowhere	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
18	When I think about past betrayals, I feel tainted	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
19	I find myself thinking about past acts of betrayal more than I should	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
20	The choices I make about my life have changed as a result of betrayals I have experienced	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
21	My experience of betrayal has changed how I think about people	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
22	When I think of past betrayals I feel distressed	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
23	I have experienced more betrayals than most people	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
24	I try to avoid thinking of past betrayals	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
25	My experience of betrayal has changed how I react to other people	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
26	My experience of betrayal has affected my judgement	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
27	My experience of betrayal has reduced my ability to trust other people	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree

28	My experience of betrayals has changed how others see me	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
29	I spend a lot of time trying to understand why the betrayal happened to me	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
30	When I think about past betrayals I feel ashamed	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
31	I frequently find myself thinking about past betrayals	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
32	I have been permanently damaged by betrayal	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
33	My preoccupation with past betrayals affects my day-to-day life	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
34	I have lost a lot because of betrayal	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
35	I often think about punishing the person / people who have betrayed me	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
36	When I think about my experiences of betrayal, I feel very angry	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
37	My experience of betrayals defines who I am	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
38	When I think about my experiences of betrayal, I still find it hard to believe it really happened.	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
39	I often find myself thinking or worrying that I am about to be betrayed	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
40	I blame myself for being betrayed	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
41	My experience of betrayal makes me feel like I am at the mercy of others most of the time	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree
42	Thinking about past betrayals, or about people who have betrayed me, makes me feel numb.	Strongly disagree	Disagree	Disagree a little	Neither agree or disagree	Agree a little	Agree	Strongly agree

Thank you for completing this questionnaire.

Appendix 24 - Study 1 information sheet

The Relationship Between Experiences of Bullying and Mental Health

PARTICIPANT INFORMATION FORM

Invitation to take part in a research project

We would like to invite you to take part in a research study. Before you decide whether you want to participate it is important for you to understand why the research is being done and what your participation will involve. Please read the following information carefully and feel free to ask us if there is anything that is not clear or if you would like further information. You do not have to decide immediately whether you want to participate so feel free to take your time to consider participation. Even if you decide to participate in the project you are free to withdraw from it at any time and without giving any reason.

What is the purpose of this study?

During our childhood it is relatively common that some of us become a victim of bullying. For some, this may be a one-off incident, and for others the experience may last for years. During this experience many people may feel embarrassed, humiliated or even betrayed that a fellow student or even a friend can behave in such a hurtful way towards us. Sometimes such emotions can lead to a person experiencing mental health problems.

Although as psychologists we have good knowledge of the relationship between anxiety and mental health issues, we have limited understanding of the role in which bullying plays in triggering anxiety and possible mental health problems. This particular study aims to expand our knowledge by investigating the possible connections between bullying, anxiety and mental health problems. There may be particular emotions that are triggered by bullying that are more related to mental health problems than others. We hope to identify the key emotions involved in this potential relationship and therefore enable us to help victims of bullying in the future.

Who can take part in this study?

We aim to recruit people who have had experiences of bullying in the past and are willing to help us in this current research project. Most of the people who take part in this study will either be associated with a charity that supports victims of bullying, or will be a friend of someone that has such links to a charity like this.

Please note that it is up to you to decide to join the study. If you decide to participate you can withdraw at any time, without giving a reason.

What would your participation involve?

If having read this Participant Information Form, you are interested in the project please provide us with the following information (see our contact details below):

- your full name
- Address (to send the pack to)

After receiving your contact details we will send you pack in the post containing a batch of questionnaires. This research project is solely based on these questionnaires so there will be no face to face meetings. Once you have completed the pack you will need to notify Chris Firmin and a freepost address will be provided so you can return the pack. You can even use the same envelope!

Please note that you will be given a copy of the Participant Information Form to keep. Also, all the data that you submit will remain confidential and will only be viewed by the researchers stated below.

What are the possible benefits of taking part in the study?

By participating in the current study you will be furthering our knowledge of the effects of bullying and how it may lead to mental health problems. The information that we generate could help many individuals avoid such difficulties.

Your well-being, while participating in the study

The questions in the surveys are about you, your experiences of bullying and reactions that you may have had in relation to these experiences. As a result these questions might be of a potentially sensitive nature. If at any stage you begin to feel you have had enough, or begin to feel upset, you can stop the survey. It is your decision if you move to the next question, survey, or even withdraw from the study completely. The top priority is your well-being. If you felt that you needed some support following the surveys, we would be very happy to arrange a time to talk. Two of the researchers are registered and experienced Clinical Psychologists.

Will my taking part in this study be kept confidential?

Yes! All the information you provide will be handled in confidence and kept securely. Your data will be allocated a unique identification number to prevent you from being identified. Any personal contact details you give us will be separated from the rest of your data. We will be the only people who will have access to the research data. We will analyse it on computers which are password-protected. If you decide to withdraw from the study we may ask for your permission to use any data you have already given us. The information you give us (or if you decide to withdraw from the study) will not in any way affect care or services you currently receive.

What will happen to the results of the research study?

The broad scientific results of this study will be written up to form a part of a doctoral thesis. The study is also likely to be presented at academic conferences and published in suitable academic journals. You will not be personally identifiable in any presentations or published documents.

Who has reviewed the study?

On designing this study the researchers submitted an ethics form to the department of psychology at The University of Bath. The committee reviewed the research proposal; the surveys implemented in the project and considered the possible ethical issues. After consideration this research was given full ethical approval.

Who can I contact regarding the study?

If you think you might be interested in taking part, or for an informal and confidential discussion about any aspect of the study, yo*u can contact us:*

By email: cjf30@bath.ac.uk
By phone: 01225 519512
By post: Chris Firmin,
Department of Psychology, 2 South,
University of Bath, Claverton Down,
Bath, BA2 7AY

What if I become distressed as a result of participating in this research?

If you have any concerns or become distressed as a result of participating in this research please contact either Chris Firmin by email at cjf30@bath.ac.uk or telephone: 01225 519512, Dr Claire Lomax via email c.lomax@bath.ac.uk or Professor Paul Salkovskis on 01225 385506 or via email pms33@bath.ac.uk

What if I want to complain?

If you have a concern about any aspect of this study or would like to complain please ask to speak to either Dr Claire Lomax via email at: c.lomax@bath.ac.uk or Professor Paul Salkovskis, on 01225 385506 or via email at: pms33@bath.ac.uk. Professor Paul Salkovskis or Claire Lomax will do their best to answer your questions and will deal with any complaints.

Thank you very much for your time.

Appendix 25 -Study 1 debrief sheet

The Relationship Between Experiences of Bullying and Mental Health

PARTICIPANT DEBRIEF SHEET

The purpose of this study

This study aimed to explore the relationship between the experiences of bullying and mental health, particularly focusing on aspects of anxiety and obsessive-compulsive problems, including but not only Obsessive Compulsive Disorder (OCD). Many individuals who have OCD often report fears of contamination, and recently the concept of 'mental contamination' has been introduced. This is the idea that a person suffering with mental contamination can actually feel dirty without physically touching anything. These feelings of dirtiness can be triggered from memories or even through imagining a distressing scenario. Simply put, some people react to being "treated like dirt" by feeling dirty!

The reason for exploring such relationships is because bullying and mental contamination share some common emotions. For example, victims of bullying often report feelings of humiliation, embarrassment, shame, guilt and betrayal. These emotions are also reported by individuals who suffer from mental contamination. The fact that there are so many shared emotions, it seemed to be a good area for investigation. OCD is commonly triggered in childhood so the researchers suggested there might be relationships between bullying, mental contamination and OCD.

If the study discovers a relationship between bullying and OCD, it could be possible for preventative measures to be created, and therefore hopefully more children will grow up without developing OCD.

If you have a concern about any aspect of this study or would like to make further enquiries, feel free to contact myself (Chris Firmin) on cjf30@bath.ac.uk, or my supervisors Dr Claire Lomax: c.lomax@bath.ac.uk or Professor Paul Salkovskis; pms33@bath.ac.uk.

Thank you very much for your time.

Appendix 26 - Study 2 information sheet

UNIVERSITY OF BATH

An investigation to explore the attitudes of therapists towards bullying and their effect on mental health problems

PARTICIPANT INFORMATION FORM

Invitation to take part in a research project

We would like to invite you to take part in a research study. Before you decide whether you want to participate it is important for you to understand why the research is being carried out and what will be expected of you. Please read the following information carefully and feel free to ask us anything that may be unclear or if you would like further information. You do not have to decide immediately whether you want to participate so feel free to take your time to consider the study. Even if you decide to participate in the project, you are free to withdraw from it at any time and without giving any reason.

What is the purpose of this study?

Nowadays bullying is becoming a more common experience for children during school years. Although psychologists have produced a great deal of research and published thousands of articles in the field of bullying, we have limited knowledge about the relationship between bullying and mental health problems. Although some disorders such as OCD, depression and PTSD can be triggered by traumatic events, it is unknown whether bullying can be an experience that may trigger such conditions.

This study aims to explore the attitudes of therapists towards bullying. We are interested in whether or not therapists and others involved in the treatment process believe that there is a relationship between bullying and mental health. We are also interested in whether patients spontaneously report experiences of bullying within therapy, and if they associate such incidences with their current difficulties.

Who can take part in this study?

We aim to recruit as many therapists as possible. We do not specify a particular practicing duration or specialisation, just as long as you do have experience of treating patients with mental health problems. The study is not targeting specific categories of mental health, we aim to investigate a broad range of mental health difficulties ranging from anxiety through to psychosis so all therapists are welcome to take part.

Please note that it is up to you to decide to join the study. If you decide to participate you can withdraw at any time, without giving a reason.

What would your participation involve?

If having read this Participant Information Form, you are interested in the project please complete a consent form initially then the demographic form. This includes questions such as years of experience, area of speciality, etc. Finally you will be asked to complete an Attitudes Towards Bullying survey which aims to investigate your views on the relationship between bullying and mental health problems.

Please note that you can keep this information sheet if you wish. All the data that you submit will remain anonymous and will only be viewed by the researchers named below.

If you decide to participate and complete the questionnaires away from the workshop, please could you send your answers to the following address:

Freepost RSCT-BXAE-BLZU
Chris Firmin
Psychology Department
University of Bath
The Avenue
Claverton Down
Bath
BA2 7AY

What are the possible benefits of taking part in the study?

By participating in the current study you will be furthering our knowledge of the relationship between bullying and mental health problems. The information that we generate could help to improve treatment strategies for patients who have experienced bullying.

Your well-being, while participating in the study
It is important to remember that all of the information that is provided in this study will always remain confidential and will only be analysed by the researchers named below. You can withdraw your data at any point in the study just by contacting the researchers and asking to do so.

Will my taking part in this study be kept confidential?
Yes! All the information you provide will be handled in confidence and kept securely. Any personal contact details you give us will be separated from the rest of your data. We will be the only people who will have access to the research data. We will analyse it on computers which are password-protected. If you decide to withdraw from the study we may ask for your permission to use any data you have already given us.

What will happen to the results of the research study?
The broad scientific results of this study will be written up to form a part of a doctoral thesis. The study is also likely to be presented at academic conferences and published in suitable academic journals. You will not be personally identifiable in any presentations or published documents.

Who has reviewed the study?
On designing this study the researchers submitted an ethics form to the department of psychology at The University of Bath. The committee reviewed the research proposal; the surveys implemented in the project and considered the possible ethical issues. After consideration this research was given full ethical approval.

Who can I contact regarding the study?
If you think you might be interested in taking part, or for an informal and confidential discussion about any aspect of the study, you can contact us:

By email: cjf30@bath.ac.uk
By phone: 01225 519512
By post: Chris Firmin,
Department of Psychology, 2 South,
University of Bath, Claverton Down,
Bath, BA2 7AY

What if I become distressed as a result of participating in this research?
If you have any concerns or become distressed as a result of participating in this research please contact either Chris Firmin by email at cjf30@bath.ac.uk or telephone: 01225 519512, Dr Claire Lomax via email c.lomax@bath.ac.uk or Professor Paul Salkovskis on 01225 385506 or via email pms33@bath.ac.uk

What if I want to complain?
If you have a concern about any aspect of this study or would like to complain please ask to speak to either Dr Claire Lomax via email at: c.lomax@bath.ac.uk or Professor Paul Salkovskis, on 01225 385506 or via email at: pms33@bath.ac.uk. Professor Paul Salkovskis or Claire Lomax will do their best to answer your questions and will deal with any complaints.

Thank you very much for your time.

Appendix 27 -Study 2 debrief sheet

An investigation to explore the attitudes of therapists towards bullying and their effect on mental health problems

PARTICIPANT DEBRIEF SHEET

The purpose of this study

This study aimed to explore the relationship between bulling and mental health problems. The reason for exploring a such relationship is because many psychological disorders can be triggered by traumatic incidents. The researchers wanted to explore whether other therapists believed that bullying could influence the development of a disorder, and to what extent the experiences have affected the individual. The researchers are also interested in the number of patients, if any, who spontaneously report being bullied and whether they associate such experiences with their current problems.

OCD in particular can contain a new concept labelled Mental Contamination. The researchers hypothesise that this type of contamination is heavily associated with betrayal, degradation and other similar emotions. Bullying is an incident that can provoke such emotions so it is plausible for the researchers to associate such experiences with Mental Contamination to some extent. Bullying may trigger Mental Contamination or possibly cause the victim to become more vulnerable to such contamination fears which may be provoked later in life.

If you have a concern about any aspect of this study or would like to make further enquiries, feel free to contact myself (Chris Firmin) on cjf30@bath.ac.uk, or my supervisors Dr Claire Lomax: c.lomax@bath.ac.uk or Professor Paul Salkovskis; pms33@bath.ac.uk.

Thank you very much for your time.

Appendix 28 - Study 3 information sheet

An investigation into potential factors that may influence experiences of OCD

PARTICIPANT INFORMATION FORM

Invitation to take part in a research project

We would like to invite you to take part in a research study. Before you decide whether you want to participate it is important for you to understand why the research is being done and what your participation will involve. Please read the following information carefully and feel free to ask us if there is anything that is not clear or if you would like further information. You do not have to decide immediately whether you want to participate so feel free to take your time to consider participation. Even if you decide to participate in the project you are free to withdraw from it at any time and without giving any reason.

What is the purpose of this study?

During our childhood it is relatively common that some of us become a victim of bullying. This may be a one-off incident or an experience that lasts for years. During this experience many people may feel embarrassed, humiliated, degraded, ashamed, disgusted or even betrayed that a fellow student or even a friend can behave in such a hurtful way towards us. Sometimes such emotions can lead to a person experiencing mental health problems.

Although as psychologists we have good knowledge of the relationship between anxiety and mental health issues, we have limited understanding of the role in which bullying plays in triggering anxiety and possible mental health problems. There is a possibility that the emotions and feelings mentioned above may influence obsessive-compulsive disorder to some degree. This particular study aims to expand our knowledge by investigating the possible connections between bullying, anxiety and mental health problems. We hope to identify the key emotions involved in this potential relationship.

Who can take part in this study?

We aim to recruit people who have had experiences of OCD in the past and are willing to help us in this research project. Some of these individuals will report experiences of bullying, and others will not.

Please note that it is up to you to decide to join the study. If you decide to participate you can withdraw at any time, without giving a reason.

What would your participation involve?

The current study is based on a set of questionnaires that we will ask you to complete. If there are any questions however that you would rather not answer, feel free to leave these blank. We'd like to remind you that all your answers will remain confidential and will only be viewed by researchers in this study.

If you wish to participate, we will need the following:

- Your full name
- Address (to send the pack to)

After receiving your contact details we will send you pack in the post containing a batch of questionnaires. It is vital that you complete the consent form, without which we will not be able to use your data. Once you have

completed the pack, you will need to notify Chris Firmin and a freepost address will be provided so you can return the pack. You can even use the same envelope!

All the data that you submit will remain confidential and will only be viewed by the researchers stated below.

What are the possible benefits of taking part in the study?

By participating in the current study you will be furthering our knowledge of the effects of bullying and how it may lead to mental health problems. The information that we generate could help many individuals avoid such difficulties.

Your well-being, while participating in the study

The questions in the surveys are about you, some of the answers that you give may be sensitive in nature and possibly painful to recall. If at any stage you begin to feel you have had enough, or begin to feel upset, please stop answering the questions. It is your decision if you move to the next question, survey, or even withdraw from the study completely. Our top priority is your well-being. If you felt that you needed some support following the surveys, we would be very happy to arrange a time to talk. Two of the researchers are registered and experienced Clinical Psychologists.

Will my taking part in this study be kept confidential?

Yes! All the information you provide will be handled in confidence and kept securely. Any personal contact details you give us will be separated from the rest of your data. We will be the only people who will have access to the research data. We will analyse it on computers which are password-protected. If you decide to withdraw from the study we will remove all your data and securely destroy your records. Your information will not in any way affect care or services you currently receive.

What will happen to the results of the research study?

The broad scientific results of this study will be written up to form a part of a doctoral thesis. The study is also likely to be presented at academic conferences and published in suitable academic journals. You will not be personally identifiable in any presentations or published documents. If you wish, I can make a summary of the results available for you to have.

Who has reviewed the study?

On designing this study the researchers submitted an ethics form to the department of psychology at The University of Bath. The committee reviewed the research proposal; the surveys implemented in the project and considered the possible ethical issues. After consideration this research was given full ethical approval.

Who can I contact regarding the study?

If you think you might be interested in taking part, or for an informal and confidential discussion about any aspect of the study, you can contact us:

By email: cjf30@bath.ac.uk
Twitter: @chrisjfirmin
Blog: chrisfirmin.wordpress.com
By post: Chris Firmin,

Department of Psychology, 2 South,
University of Bath, Claverton Down,
Bath, BA2 7AY

What if I become distressed as a result of participating in this research?

If you have any concerns or become distressed as a result of participating in this research please contact either Chris Firmin with the details above, Dr Claire Lomax via email c.lomax@bath.ac.uk or Professor Paul Salkovskis on 01225 385506 or via email pms33@bath.ac.uk.

What if I want to complain?

If you have a concern about any aspect of this study or would like to complain please ask to speak to either Dr Claire Lomax via email at: c.lomax@bath.ac.uk or Professor Paul Salkovskis, on 01225 385506 or via email at: pms33@bath.ac.uk. Professor Paul Salkovskis or Claire Lomax will do their best to answer your questions and will deal with any complaints.

Thank you very much for your time.

Appendix 29 -Study 3 debrief sheet

An investigation into potential factors that may influence experiences of OCD

PARTICIPANT DEBRIEF SHEET

The purpose of this study

This study aimed to explore the relationship between the experiences of bullying and obsessive-compulsive disorder (OCD), particularly focusing on mental contamination. Many individuals who have OCD often report fears of contamination, which are typically thought of as requiring a physical element, i.e. touching a harmful substance. Recently the concept of 'mental contamination' has been introduced, which is an internal, emotional feeling of dirtiness, that can actually be triggered without physically touching anything. These feelings of dirtiness can be triggered from memories or even through imagining a distressing scenario. Simply put, some people react to being "treated like dirt" by feeling dirty!

We are exploring the potential relationship between bullying and mental contamination because some factors that we believe may trigger feelings of internal dirtiness are often reported by individuals who have suffered with bullying. For example, victims of bullying often report feelings of humiliation, embarrassment, shame, guilt and betrayal. These emotions are also reported by individuals who suffer from mental contamination. Due to this overlap, we believe that bullying may affect the possibility of developing mental contamination in some people. It could possibly trigger mental contamination immediately, but it is more likely to cause some people to become more vulnerable to developing it later on in life.

If the study discovers evidence for a potential relationship between bullying and OCD, it could possibly lead to the development of preventative measures that hopefully will help more people in the future, in terms of bullying and obsessive behaviours

If you have a concern about any aspect of this study or would like to make further enquiries, feel free to contact myself (Chris Firmin) on cjf30@bath.ac.uk, or my supervisors Dr Claire Lomax: c.lomax@bath.ac.uk or Professor Paul Salkovskis; pms33@bath.ac.uk.

Thank you very much for your time and effort in completing this study.